

7621

CERTIFICATE OF DEATH

07570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodland Beach		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE BENJAMIN ALBRITTON		4. DATE OF DEATH Month Day Year July 18, 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Gov.		10b. KIND OF BUSINESS OR INDUSTRY Printer	11. BIRTHPLACE (State or foreign country) Farmington, Ky
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mina B. Albritton- wife- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia + pyelitis 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Bladder DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 weeks at least 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov , 19 59 , to July 18 , 19 60 , that I last saw the deceased alive on July 17 , 19 60 , and that death occurred at 1 A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Shady Side, Maryland DATE SIGNED 7/19/60 ACTUAL SIGNATURE Willard F. Smith M.D. PHYSICIAN'S NAME (Type) Willard F. Smith MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 20, 1960	22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hopping Funeral Home Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE JUL 21 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

02579

CERTIFICATE OF DEATH

1981

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7622

CERTIFICATE OF DEATH

07571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 7 mo. 5 years 28 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1932 W. Lanvale Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Georgia Autry				4. DATE OF DEATH Month Day Year 7 29 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 28, 1896	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William McSwain				14. MOTHER'S MAIDEN NAME Annie Bobbett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address A. A. County, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Hyperthyroidism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from -----, 19-----, to 7/29 , 19 60 , that I last saw the deceased alive on 7/29 , 19 60 , and that death occurred at 7:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 7/29/60 ACTUAL SIGNATURE L. Benedict, M. D. M.D. Crownsville State Hospital, Md. 7/29/60 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 1, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James morton jr. ADDRESS 916 Pennsylvania Ave				24a. REC'D BY REGISTRAR DATE AUG 2 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7584

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07572

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>O'NEIL</u> Last <u>BERRYMAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1891</u>
9. AGE (In years lost birthday) <u>68 yrs.</u>		10. IF UNDER 1 YEAR Months <u>68</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAN CO. RETIRED 8 YRS Maryland, Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN BERRYMAN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA HAGGART</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215 09 6026</u>	
17. INFORMANT <u>MRS ROSAMOND BERRYMAN</u>		Address <u>SEVERNA PARK</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1960</u> to <u>July 6, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard N. Peeler</u> M.D.		22b. DATE <u>2:35 P.M.</u> 22b. DATE SIGNED <u>7-6-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard N. PEELER</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/9/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC. BALTIMORE MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 8 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1984



CHIEF OF BUREAU



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

7623

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07573

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Pasadena, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 Coplar Ridge, Cedar Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>EUGENE</u> Last <u>BEZIAT</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 19, 1911</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR: Months <u>48</u> Days <u>48</u> Hours <u>48</u> Min. <u>48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIP FITTER, U.S. COAST GUARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROY ELLSWORTH BEZIAT</u>		14. MOTHER'S MAIDEN NAME <u>ELSIE MOCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>U.S. Govt</u>	
17. INFORMANT <u>MRS. EMMA BEZIAT</u> Address <u>PASADENA, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>42 Q1 Acute coronary thrombosis</u> DUE TO (b) <u>30 MINUTES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>42 Q1</u> DUE TO (b) <u>30 MINUTES</u> DUE TO (c) <u>42 Q1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 2, 1950</u> to <u>JULY 12, 1960</u> , that (I) (we) last saw the deceased alive on <u>JULY 12, 1960</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>R. M. McLaughlin</u>		22b. DATE <u>July 12, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>		22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/15/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Elbridge Cem. Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u> ADDRESS <u>130 E. Fort Ave. # 30</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Aunt Cornelia Thompson
No 42 Box Mrs. Bessie Dean President W.P.
Roy Estworth Dean Elsie Hook
Ship Fitter U.S. Coast Guard Maryland N.C.

Mary White *
Jesse Dean July 17

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1894 4 20

R. W. McChesney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

7585

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07574

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS --	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Oswald Last BOTELER		4. DATE OF DEATH Month July Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1891
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tenant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Charles Lyn Boteler		14. MOTHER'S MAIDEN NAME Margaret Ann Perrie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Isabel I. Boteler-Same as Item #2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral artery thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 9 da			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 30, 1960 , to July 6, 1960 , that (I) did last saw the deceased alive on July 6, 1960 , and that death occurred at 2:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Richard N. Peeler		22b. DATE SIGNED 7-7-60	
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/11/60	
23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		23d. LOCATION (City, town, or county) (State) Clinton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro		25a. REC'D BY REGISTRAR JUL 11 '60	
ADDRESS Md.		25b. REGISTRAR'S SIGNATURE Arthur J. Hines	

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CERTIFICATE OF DEATH

1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7624
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 07575

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3 yrs. 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turner's Station	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 111 Avon Beach Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Ruth Last Bumgardner				4. DATE OF DEATH Month 7 Day 6 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 25, 1903	
9. AGE (In years lost birthday) yrs. 56		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56		IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min. 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Hurt				14. MOTHER'S MAIDEN NAME Sue Stokes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-24-6385		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) -----				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour ----- o. m. ----- p. m. 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 6/14 , 19 57 , to 7/6 , 19 60 , that I last saw the deceased alive on 7/6 , 19 60 , and that death occurred at 5:45 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 7/6/60 ACTUAL SIGNATURE L. Benedict M.D. L. Benedict, M. D. Crownsville State Hospital, Md. 7/6/60 PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 7/6/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-10-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) A. A. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles B. Lewis				ADDRESS 1639 N. Beardswan		24a. REC'D BY REGISTRAR DATE 8 '60	
						24b. REGISTRAR'S SIGNATURE Charles S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

7586

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07576

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 13 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Henryetta WAGNER CARPENTER		4. DATE OF DEATH Month Day Year July 13 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-1911
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS	
11. BIRTHPLACE (State or foreign country) Arizona		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS WAGNER		14. MOTHER'S MAIDEN NAME ODA JOSEPHINE WRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT THOMAS P CARPENTER # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17.0X DUE TO Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Breast (c)		INTERVAL BETWEEN ONSET AND DEATH 8 weeks 2 yrs 1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 6, 1957, to July 13, 1960, that (I) (we) last saw the deceased alive on July 13, 1960, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE James R. Martin		22b. DATE SIGNED 7/14/60	
22c. PHYSICIAN'S NAME (Type) James R. Martin		22d. ADDRESS 6 Shaw St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 7-16-1960	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION (City, town, or county) (State) PRINCE GEORGE CO. MD	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR, SON ANNAPOLIS MD		25a. REC'D BY REGISTRAR DATE JUL 18 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kincaid			

05520

CERTIFICATE OF DEATH

7588

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John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

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John Doe

John Doe

John Doe

John Doe

John Doe

7625

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>2 years</u> <u>5 mo. 13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>Unknown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Lee</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Tissa ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decubital Ulcers</u> DUE TO (c) <u>Central Nervous System Syphilis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>			
20c. TIME OF INJURY Hour <u>-----</u> a. m. <u>-----</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/23</u> , 19 <u>58</u> , to <u>7/6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>60</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Maryland</u> DATE SIGNED <u>7/7/60</u>							
ACTUAL SIGNATURE <u>Hildegard Heard Reissman</u>				M.D. <u>Crownsville State Hospital, Maryland</u> <u>7/7/60</u>			
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M.D.</u>				<u>Crownsville State Hospital, Maryland</u> <u>7/7/60</u>			
22a. BURIAL, CREMATION, (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Reburied</u>		<u>7/15/60</u>		<u>Univ. of Maryland</u>		<u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese II</u>				ADDRESS <u>108 W. Wash St. E. Baltimore</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Reese</u>	
24a. REC'D BY REGISTRAR <u>19 60</u>				DATE <u>7/7/60</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7626

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 201, Route 5		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 201, Route 5, Magothy Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Magothy Beach, Pasadena				d. STREET ADDRESS 1 Pasadena		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Johanna Middle Paul Last Colyer				4. DATE OF DEATH Month July Day 30 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1867		9. AGE (In years last birthday) yrs. 93	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Howard Tydings, Same as			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) cardiac decompensation INTERVAL BETWEEN ONSET AND DEATH 40 hours 2 years 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1959 , to July 30, 1960 , that I last saw the deceased alive on July 29, 1960 , and that death occurred at 11 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3708 Monntain Rd. Pasadena, Md. DATE SIGNED 7/30/60 ACTUAL SIGNATURE R.M. McLaughlin M.D. PHYSICIAN'S NAME (Type) R.M. McLaughlin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/2/60		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE AUG 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7627

CERTIFICATE OF DEATH

Reg. Dist. No. 07580

1. PLACE OF DEATH a. COUNTY A. A.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 404 Forest View Road				d. STREET ADDRESS 404 Forest View Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROSINA Middle B. Last CONAWAY				4. DATE OF DEATH Month July Day 14 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 29, 1873	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Henry William Herman				14. MOTHER'S MAIDEN NAME Rosa Dora Oehrl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Florence Hennessy-404 Forest View Rd.		Address Linth. Hgts.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basaloid Hemorrhage 331X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10-15 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/14/60 , 19 60 , to 7/14/60 , 19 60 , that I last saw the deceased alive on 7/14/60 , 19 60 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas. L. Ball Jr. M.D.				ADDRESS (Street, city or town, state) Linthicum Md			
DATE SIGNED 7/14/60							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/60		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balt.				24a. REC'D BY REGISTRAR DATE JUL 14 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

7588
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07581

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 1146 Defense Highway	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE W. COOLEY Jr.		First Middle Last		4. DATE OF DEATH July 18 1960		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 18 - 1940	9. AGE (In years less than day) 19 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Life Guard		10b. KIND OF BUSINESS OR INDUSTRY Public Beach		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME George W. Cooley Sr.				14. MOTHER'S MAIDEN NAME Elilie Sondergaard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1958-1960		17. INFORMANT George W. Cooley		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab Wound of Chest. 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed in chest.					
20c. TIME OF INJURY Hour 9:00 p.m. Month, Day, Year 7/18 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House		20f. (City or town) Annapolis		(County) Anne Arundel (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/19/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-22-1960	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		22d. LOCATION (City, town, or country) Annapolis		(State) Md	
23. FUNERAL DIRECTOR John M. Taylor Sons		ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR JUL 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MEDICAL CERTIFICATION

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02/01/7

[Faint, illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7628

CERTIFICATE OF DEATH

07582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Heights</u> c. LENGTH OF STAY IN 1b <u>Over 6 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>901 Victory Avenue</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rose Cover</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>July 20th</u> <u>19 60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/8/98</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Kress</u>		14. MOTHER'S MAIDEN NAME <u>? Wiegand</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-10-4576</u>	
17. INFORMANT <u>Miss Jean Cover (daughter)</u>		Address <u>901 Victory Avenue #25</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-vascular diseases</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2hrs.</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>56</u> , to <u>July 20th.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 16th.</u> , 19 <u>60</u> , and that death occurred at <u>10.15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>7/21/60</u>	
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tichner</u>		ADDRESS <u>Baltimore - 17, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Online S. Hume</u>	

• **1998** – 1999

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7589

CERTIFICATE OF DEATH

Reg. Dist. No. 07583

1. PLACE OF DEATH a. COUNTY <u>HUNNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X MAYO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H.A. GENERAL Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE MYRTLE COX</u>				4. DATE OF DEATH Month Day Year <u>7 8 19 60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-1914</u>	9. AGE (In years lost birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECT.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.E.E.S</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>"UNK"</u>				14. MOTHER'S MAIDEN NAME <u>"UNK"</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>WILLIAM F. COX SR.</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>757.1</u> DUE TO <u>Polycystic renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>60</u> , to <u>7/8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/8</u> , 19 <u>60</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D.				ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST</u> DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>				<u>ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-11-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. L. Sons (Annapolis) Md.</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUL 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]	
PLACE OF BIRTH [Handwritten: New York City]		DATE OF BIRTH [Handwritten: Jan 15, 1880]		PLACE OF DEATH [Handwritten: Boston, Mass.]	
OCCUPATION [Handwritten: Clerk]		CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]	
DATE OF DEATH [Handwritten: Feb 10, 1920]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF INTERMENT [Handwritten: Mount Hope Cemetery]	
SIGNATURE OF PHYSICIAN [Handwritten: Dr. J. Smith]		SIGNATURE OF CLERK [Handwritten: A. Brown]		SIGNATURE OF DECEASED [Blank]	
SIGNATURE OF WITNESS [Handwritten: J. Doe]		SIGNATURE OF DECEASED [Blank]		SIGNATURE OF DECEASED [Blank]	

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 444. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 8, 9 Film G268-8-10-60 et

07584

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Shades River c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pier of Shades River		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS 16X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM H. CRAWFORD		4. DATE OF DEATH Month Day Year July 9, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1904
9. AGE (In years last birthday) 56 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer	11. BIRTHPLACE (State or foreign country) Washington D C.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME William Harrison	
14. MOTHER'S MAIDEN NAME Elizabeth Ann Brown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Raymond L Crawford Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 850X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Thrown overboard when his boat tipped over	
20c. TIME OF INJURY Hour XXXX p.m. Month, Day, Year 7/9/ 19 60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shades River	20f. (City or town) (County) (State) Anne Arundel, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/11/60	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 13, 1960	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington D C
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE JUL 15 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss	



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STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF EXAMINER

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7590

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07585

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ONLY FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Asa</u> Middle <u>Biggs</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 18, 1906</u>	
9. AGE (In years lost birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George B. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Sally F. Harding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>213 18 6980</u>		17. INFORMANT <u>Mrs Jack Erbe- Daughter- same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> <u>1955</u> , to <u>July 23</u> , <u>1960</u> , that (I) <u>last</u> saw the deceased alive on <u>July 23</u> , <u>1960</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward S. Beck</u>				22b. DATE <u>7/25/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>	
22d. ADDRESS <u>71 Franklin St., Annapolis, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 26, 60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley Funeral Home,</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 27 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kane</u>	

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MAINTENANCE DEPARTMENT

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MAINTENANCE DEPARTMENT OF INDIANA
OFFICE OF THE STATE ENGINEER
INDIANAPOLIS, INDIANA

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INDIANAPOLIS, INDIANA

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1618 1625 1632 1639 1646 1653 1660 1667 1674 1681 1688 1695 1702 1709 1716 1723 1730 1737 1744 1751 1758 1765 1772 1779 1786 1793 1800 1807 1814 1821 1828 1835 1842 1849 1856 1863 1870 1877 1884 1891 1898 1905 1912 1919 1926 1933 1940 1947 1954 1961 1968 1975 1982 1989 1996 2003 2010 2017 2024 2031 2038 2045 2052 2059 2066 2073 2080 2087 2094 2101 2108 2115 2122 2129 2136 2143 2150 2157 2164 2171 2178 2185 2192 2199 2206 2213 2220 2227 2234 2241 2248 2255 2262 2269 2276 2283 2290 2297 2304 2311 2318 2325 2332 2339 2346 2353 2360 2367 2374 2381 2388 2395 2402 2409 2416 2423 2430 2437 2444 2451 2458 2465 2472 2479 2486 2493 2500 2507 2514 2521 2528 2535 2542 2549 2556 2563 2570 2577 2584 2591 2598 2605 2612 2619 2626 2633 2640 2647 2654 2661 2668 2675 2682 2689 2696 2703 2710 2717 2724 2731 2738 2745 2752 2759 2766 2773 2780 2787 2794 2801 2808 2815 2822 2829 2836 2843 2850 2857 2864 2871 2878 2885 2892 2899 2906 2913 2920 2927 2934 2941 2948 2955 2962 2969 2976 2983 2990 2997 3004 3011 3018 3025 3032 3039 3046 3053 3060 3067 3074 3081 3088 3095 3102 3109 3116 3123 3130 3137 3144 3151 3158 3165 3172 3179 3186 3193 3200 3207 3214 3221 3228 3235 3242 3249 3256 3263 3270 3277 3284 3291 3298 3305 3312 3319 3326 3333 3340 3347 3354 3361 3368 3375 3382 3389 3396 3403 3410 3417 3424 3431 3438 3445 3452 3459 3466 3473 3480 3487 3494 3501 3508 3515 3522 3529 3536 3543 3550 3557 3564 3571 3578 3585 3592 3599 3606 3613 3620 3627 3634 3641 3648 3655 3662 3669 3676 3683 3690 3697 3704 3711 3718 3725 3732 3739 3746 3753 3760 3767 3774 3781 3788 3795 3802 3809 3816 3823 3830 3837 3844 3851 3858 3865 3872 3879 3886 3893 3900 3907 3914 3921 3928 3935 3942 3949 3956 3963 3970 3977 3984 3991 3998 4005 4012 4019 4026 4033 4040 4047 4054 4061 4068 4075 4082 4089 4096 4103 4110 4117 4124 4131 4138 4145 4152 4159 4166 4173 4180 4187 4194 4201 4208 4215 4222 4229 4236 4243 4250 4257 4264 4271 4278 4285 4292 4299 4306 4313 4320 4327 4334 4341 4348 4355 4362 4369 4376 4383 4390 4397 4404 4411 4418 4425 4432 4439 4446 4453 4460 4467 4474 4481 4488 4495 4502 4509 4516 4523 4530 4537 4544 4551 4558 4565 4572 4579 4586 4593 4600 4607 4614 4621 4628 4635 4642 4649 4656 4663 4670 4677 4684 4691 4698 4705 4712 4719 4726 4733 4740 4747 4754 4761 4768 4775 4782 4789 4796 4803 4810 4817 4824 4831 4838 4845 4852 4859 4866 4873 4880 4887 4894 4901 4908 4915 4922 4929 4936 4943 4950 4957 4964 4971 4978 4985 4992 4999 5006 5013 5020 5027 5034 5041 5048 5055 5062 5069 5076 5083 5090 5097 5104 5111 5118 5125 5132 5139 5146 5153 5160 5167 5174 5181 5188 5195 5202 5209 5216 5223 5230 5237 5244 5251 5258 5265 5272 5279 5286 5293 5300 5307 5314 5321 5328 5335 5342 5349 5356 5363 5370 5377 5384 5391 5398 5405 5412 5419 5426 5433 5440 5447 5454 5461 5468 5475 5482 5489 5496 5503 5510 5517 5524 5531 5538 5545 5552 5559 5566 5573 5580 5587 5594 5601 5608 5615 5622 5629 5636 5643 5650 5657 5664 5671 5678 5685 5692 5699 5706 5713 5720 5727 5734 5741 5748 5755 5762 5769 5776 5783 5790 5797 5804 5811 5818 5825 5832 5839 5846 5853 5860 5867 5874 5881 5888 5895 5902 5909 5916 5923 5930 5937 5944 5951 5958 5965 5972 5979 5986 5993 6000 6007 6014 6021 6028 6035 6042 6049 6056 6063 6070 6077 6084 6091 6098 6105 6112 6119 6126 6133 6140 6147 6154 6161 6168 6175 6182 6189 6196 6203 6210 6217 6224 6231 6238 6245 6252 6259 6266 6273 6280 6287 6294 6301 6308 6315 6322 6329 6336 6343 6350 6357 6364 6371 6378 6385 6392 6399 6406 6413 6420 6427 6434 6441 6448 6455 6462 6469 6476 6483 6490 6497 6504 6511 6518 6525 6532 6539 6546 6553 6560 6567 6574 6581 6588 6595 6602 6609 6616 6623 6630 6637 6644 6651 6658 6665 6672 6679 6686 6693 6700 6707 6714 6721 6728 6735 6742 6749 6756 6763 6770 6777 6784 6791 6798 6805 6812 6819 6826 6833 6840 6847 6854 6861 6868 6875 6882 6889 6896 6903 6910 6917 6924 6931 6938 6945 6952 6959 6966 6973 6980 6987 6994 7001 7008 7015 7022 7029 7036 7043 7050 7057 7064 7071 7078 7085 7092 7099 7106 7113 7120 7127 7134 7141 7148 7155 7162 7169 7176 7183 7190 7197 7204 7211 7218 7225 7232 7239 7246 7253 7260 7267 7274 7281 7288 7295 7302 7309 7316 7323 7330 7337 7344 7351 7358 7365 7372 7379 7386 7393 7400 7407 7414 7421 7428 7435 7442 7449 7456 7463 7470 7477 7484 7491 7498 7505 7512 7519 7526 7533 7540 7547 7554 7561 7568 7575 7582 7589 7596 7603 7610 7617 7624 7631 7638 7645 7652 7659 7666 7673 7680 7687 7694 7701 7708 7715 7722 7729 7736 7743 7750 7757 7764 7771 7778 7785 7792 7799 7806 7813 7820 7827 7834 7841 7848 7855 7862 7869 7876 7883 7890 7897 7904 7911 7918 7925 7932 7939 7946 7953 7960 7967 7974 7981 7988 7995 8002 8009 8016 8023 8030 8037 8044 8051 8058 8065 8072 8079 8086 8093 8100 8107 8114 8121 8128 8135 8142 8149 8156 8163 8170 8177 8184 8191 8198 8205 8212 8219 8226 8233 8240 8247 8254 8261 8268 8275 8282 8289 8296 8303 8310 8317 8324 8331 8338 8345 8352 8359 8366 8373 8380 8387 8394 8401 8408 8415 8422 8429 8436 8443 8450 8457 8464 8471 8478 8485 8492 8499 8506 8513 8520 8527 8534 8541 8548 8555 8562 8569 8576 8583 8590 8597 8604 8611 8618 8625 8632 8639 8646 8653 8660 8667 8674 8681 8688 8695 8702 8709 8716 8723 8730 8737 8744 8751</

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

1 FOR STATE HEALTH DEPT.

TO JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the delay should be noted in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7631 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07587									
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park P.O.</u>					c. LENGTH OF STAY IN 1b <u>15 years</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carrilton Manor</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Dorothy L. Dunbar</u>					4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1960</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/5/79</u>		9. AGE (In years last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Chillicothe, Ohio.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Lair</u>					14. MOTHER'S MAIDEN NAME <u>Lida Bickham</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
					17. INFORMANT <u>Mr. Philipp Franklin (son)</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/30/60</u>				
					DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 3-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington Va</u>			
23. FUNERAL DIRECTOR <u>John M. Taylor Sons</u>					24a. REC'D BY REGISTRAR <u>August 4 '60</u>				
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>				

01337

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01337



01337

7618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orchard Beach</u>				c. LENGTH OF STAY IN 1b <u>30yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1104 BEACH PROMENADE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAXIMILLAN CONRAD FAHMULLER</u>				4. DATE OF DEATH Month Day Year <u>July 28 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 1, 1902</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE MANAGER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CONRAD FAHMULLER</u>				14. MOTHER'S MAIDEN NAME <u>KUNIGUNDA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>7</u>		17. INFORMANT <u>Christine Fahmuller</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> 420-1 DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 years</u> (c) <u>2 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 mins.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 10, 1958</u> to <u>July 28, 1960</u> , that I last saw the deceased alive on <u>Feb 15, 1960</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u> DATE SIGNED <u>July 29, 1960</u>							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.				PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-1-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CECIL HILL</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab</u> ADDRESS <u>3101 Frederick Ave</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22

100

10

George Washington
Washington City D.C.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7632

CERTIFICATE OF DEATH

07588

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A. Co -</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LONG POINT PASADENA, MD</u>		d. STREET ADDRESS <u>427 E. LOBBRAINE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>NATHANIEL</u> Last <u>FERCIOT</u>		4. DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEGRAPH OPER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MCCUBBIN LECO</u>	
11. BIRTHPLACE (State or foreign country) <u>WESTERNPORT, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHAS N. FERCIOT</u>		14. MOTHER'S MAIDEN NAME <u>MARY A MC GUIRK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MR THOS FERCIOT, JR</u>	
17. INFORMANT <u>MR THOS FERCIOT, JR</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 acute cerebrovascular accident</u> DUE TO <u>Arteriosclerotic Cerebrovascular disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Coronary artery disease</u> DUE TO <u>2 years</u> (c) <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1960</u> , to <u>July 21, 1960</u> , that I last saw the deceased alive on <u>July 20, 1960</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>		ADDRESS (Street, city or town, state) <u>3108 Mountain Road Pasadena Md.</u>	
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>		DATE SIGNED <u>7/21/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/25/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WIEDEFELD & SON</u>		ADDRESS <u>Greenmount Ave & 22nd</u>	
24a. REC'D BY REGISTRAR <u>JUL 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

CERTIFICATE OF DEATH

See Ord. for

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL STATUS		12. CAUSE OF DEATH	
13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH		16. SEX OF DECEASED		17. AGE OF DECEASED		18. CAUSE OF DEATH	
19. PLACE OF DEATH		20. DATE OF DEATH		21. TIME OF DEATH		22. SEX OF DECEASED		23. AGE OF DECEASED		24. CAUSE OF DEATH	
25. PLACE OF DEATH		26. DATE OF DEATH		27. TIME OF DEATH		28. SEX OF DECEASED		29. AGE OF DECEASED		30. CAUSE OF DEATH	
31. PLACE OF DEATH		32. DATE OF DEATH		33. TIME OF DEATH		34. SEX OF DECEASED		35. AGE OF DECEASED		36. CAUSE OF DEATH	
37. PLACE OF DEATH		38. DATE OF DEATH		39. TIME OF DEATH		40. SEX OF DECEASED		41. AGE OF DECEASED		42. CAUSE OF DEATH	
43. PLACE OF DEATH		44. DATE OF DEATH		45. TIME OF DEATH		46. SEX OF DECEASED		47. AGE OF DECEASED		48. CAUSE OF DEATH	
49. PLACE OF DEATH		50. DATE OF DEATH		51. TIME OF DEATH		52. SEX OF DECEASED		53. AGE OF DECEASED		54. CAUSE OF DEATH	
55. PLACE OF DEATH		56. DATE OF DEATH		57. TIME OF DEATH		58. SEX OF DECEASED		59. AGE OF DECEASED		60. CAUSE OF DEATH	
61. PLACE OF DEATH		62. DATE OF DEATH		63. TIME OF DEATH		64. SEX OF DECEASED		65. AGE OF DECEASED		66. CAUSE OF DEATH	
67. PLACE OF DEATH		68. DATE OF DEATH		69. TIME OF DEATH		70. SEX OF DECEASED		71. AGE OF DECEASED		72. CAUSE OF DEATH	
73. PLACE OF DEATH		74. DATE OF DEATH		75. TIME OF DEATH		76. SEX OF DECEASED		77. AGE OF DECEASED		78. CAUSE OF DEATH	
79. PLACE OF DEATH		80. DATE OF DEATH		81. TIME OF DEATH		82. SEX OF DECEASED		83. AGE OF DECEASED		84. CAUSE OF DEATH	
85. PLACE OF DEATH		86. DATE OF DEATH		87. TIME OF DEATH		88. SEX OF DECEASED		89. AGE OF DECEASED		90. CAUSE OF DEATH	
91. PLACE OF DEATH		92. DATE OF DEATH		93. TIME OF DEATH		94. SEX OF DECEASED		95. AGE OF DECEASED		96. CAUSE OF DEATH	
97. PLACE OF DEATH		98. DATE OF DEATH		99. TIME OF DEATH		100. SEX OF DECEASED		101. AGE OF DECEASED		102. CAUSE OF DEATH	
103. PLACE OF DEATH		104. DATE OF DEATH		105. TIME OF DEATH		106. SEX OF DECEASED		107. AGE OF DECEASED		108. CAUSE OF DEATH	
109. PLACE OF DEATH		110. DATE OF DEATH		111. TIME OF DEATH		112. SEX OF DECEASED		113. AGE OF DECEASED		114. CAUSE OF DEATH	
115. PLACE OF DEATH		116. DATE OF DEATH		117. TIME OF DEATH		118. SEX OF DECEASED		119. AGE OF DECEASED		120. CAUSE OF DEATH	
121. PLACE OF DEATH		122. DATE OF DEATH		123. TIME OF DEATH		124. SEX OF DECEASED		125. AGE OF DECEASED		126. CAUSE OF DEATH	
127. PLACE OF DEATH		128. DATE OF DEATH		129. TIME OF DEATH		130. SEX OF DECEASED		131. AGE OF DECEASED		132. CAUSE OF DEATH	
133. PLACE OF DEATH		134. DATE OF DEATH		135. TIME OF DEATH		136. SEX OF DECEASED		137. AGE OF DECEASED		138. CAUSE OF DEATH	
139. PLACE OF DEATH		140. DATE OF DEATH		141. TIME OF DEATH		142. SEX OF DECEASED		143. AGE OF DECEASED		144. CAUSE OF DEATH	
145. PLACE OF DEATH		146. DATE OF DEATH		147. TIME OF DEATH		148. SEX OF DECEASED		149. AGE OF DECEASED		150. CAUSE OF DEATH	
151. PLACE OF DEATH		152. DATE OF DEATH		153. TIME OF DEATH		154. SEX OF DECEASED		155. AGE OF DECEASED		156. CAUSE OF DEATH	
157. PLACE OF DEATH		158. DATE OF DEATH		159. TIME OF DEATH		160. SEX OF DECEASED		161. AGE OF DECEASED		162. CAUSE OF DEATH	
163. PLACE OF DEATH		164. DATE OF DEATH		165. TIME OF DEATH		166. SEX OF DECEASED		167. AGE OF DECEASED		168. CAUSE OF DEATH	
169. PLACE OF DEATH		170. DATE OF DEATH		171. TIME OF DEATH		172. SEX OF DECEASED		173. AGE OF DECEASED		174. CAUSE OF DEATH	
175. PLACE OF DEATH		176. DATE OF DEATH		177. TIME OF DEATH		178. SEX OF DECEASED		179. AGE OF DECEASED		180. CAUSE OF DEATH	
181. PLACE OF DEATH		182. DATE OF DEATH		183. TIME OF DEATH		184. SEX OF DECEASED		185. AGE OF DECEASED		186. CAUSE OF DEATH	
187. PLACE OF DEATH		188. DATE OF DEATH		189. TIME OF DEATH		190. SEX OF DECEASED		191. AGE OF DECEASED		192. CAUSE OF DEATH	
193. PLACE OF DEATH		194. DATE OF DEATH		195. TIME OF DEATH		196. SEX OF DECEASED		197. AGE OF DECEASED		198. CAUSE OF DEATH	
199. PLACE OF DEATH		200. DATE OF DEATH		201. TIME OF DEATH		202. SEX OF DECEASED		203. AGE OF DECEASED		204. CAUSE OF DEATH	
205. PLACE OF DEATH		206. DATE OF DEATH		207. TIME OF DEATH		208. SEX OF DECEASED		209. AGE OF DECEASED		210. CAUSE OF DEATH	
211. PLACE OF DEATH		212. DATE OF DEATH		213. TIME OF DEATH		214. SEX OF DECEASED		215. AGE OF DECEASED		216. CAUSE OF DEATH	
217. PLACE OF DEATH		218. DATE OF DEATH		219. TIME OF DEATH		220. SEX OF DECEASED		221. AGE OF DECEASED		222. CAUSE OF DEATH	
223. PLACE OF DEATH		224. DATE OF DEATH		225. TIME OF DEATH		226. SEX OF DECEASED		227. AGE OF DECEASED		228. CAUSE OF DEATH	
229. PLACE OF DEATH		230. DATE OF DEATH		231. TIME OF DEATH		232. SEX OF DECEASED		233. AGE OF DECEASED		234. CAUSE OF DEATH	
235. PLACE OF DEATH		236. DATE OF DEATH		237. TIME OF DEATH		238. SEX OF DECEASED		239. AGE OF DECEASED		240. CAUSE OF DEATH	
241. PLACE OF DEATH		242. DATE OF DEATH		243. TIME OF DEATH		244. SEX OF DECEASED		245. AGE OF DECEASED		246. CAUSE OF DEATH	
247. PLACE OF DEATH		248. DATE OF DEATH		249. TIME OF DEATH		250. SEX OF DECEASED		251. AGE OF DECEASED		252. CAUSE OF DEATH	
253. PLACE OF DEATH		254. DATE OF DEATH		255. TIME OF DEATH		256. SEX OF DECEASED		257. AGE OF DECEASED		258. CAUSE OF DEATH	
259. PLACE OF DEATH		260. DATE OF DEATH		261. TIME OF DEATH		262. SEX OF DECEASED		263. AGE OF DECEASED		264. CAUSE OF DEATH	
265. PLACE OF DEATH		266. DATE OF DEATH		267. TIME OF DEATH		268. SEX OF DECEASED		269. AGE OF DECEASED		270. CAUSE OF DEATH	
271. PLACE OF DEATH		272. DATE OF DEATH		273. TIME OF DEATH		274. SEX OF DECEASED		275. AGE OF DECEASED		276. CAUSE OF DEATH	
277. PLACE OF DEATH		278. DATE OF DEATH		279. TIME OF DEATH		280. SEX OF DECEASED		281. AGE OF DECEASED		282. CAUSE OF DEATH	
283. PLACE OF DEATH		284. DATE OF DEATH		285. TIME OF DEATH		286. SEX OF DECEASED		287. AGE OF DECEASED		288. CAUSE OF DEATH	
289. PLACE OF DEATH		290. DATE OF DEATH		291. TIME OF DEATH		292. SEX OF DECEASED		293. AGE OF DECEASED		294. CAUSE OF DEATH	
295. PLACE OF DEATH		296. DATE OF DEATH		297. TIME OF DEATH		298. SEX OF DECEASED		299. AGE OF DECEASED		300. CAUSE OF DEATH	
301. PLACE OF DEATH		302. DATE OF DEATH		303. TIME OF DEATH		304. SEX OF DECEASED		305. AGE OF DECEASED		306. CAUSE OF DEATH	
307. PLACE OF DEATH		308. DATE OF DEATH		309. TIME OF DEATH		310. SEX OF DECEASED		311. AGE OF DECEASED		312. CAUSE OF DEATH	
313. PLACE OF DEATH		314. DATE OF DEATH		315. TIME OF DEATH		316. SEX OF DECEASED		317. AGE OF DECEASED		318. CAUSE OF DEATH	
319. PLACE OF DEATH		320. DATE OF DEATH		321. TIME OF DEATH		322. SEX OF DECEASED		323. AGE OF DECEASED		324. CAUSE OF DEATH	
325. PLACE OF DEATH		326. DATE OF DEATH		327. TIME OF DEATH		328. SEX OF DECEASED		329. AGE OF DECEASED		330. CAUSE OF DEATH	
331. PLACE OF DEATH		332. DATE OF DEATH		333. TIME OF DEATH		334. SEX OF DECEASED		335. AGE OF DECEASED		336. CAUSE OF DEATH	
337. PLACE OF DEATH		338. DATE OF DEATH		339. TIME OF DEATH		340. SEX OF DECEASED		341. AGE OF DECEASED		342. CAUSE OF DEATH	
343. PLACE OF DEATH		344. DATE OF DEATH		345. TIME OF DEATH		346. SEX OF DECEASED		347. AGE OF DECEASED		348. CAUSE OF DEATH	
349. PLACE OF DEATH		350. DATE OF DEATH		351. TIME OF DEATH		352. SEX OF DECEASED		353. AGE OF DECEASED		354. CAUSE OF DEATH	
355. PLACE OF DEATH		356. DATE OF DEATH		357. TIME OF DEATH		358. SEX OF DECEASED		359. AGE OF DECEASED		360. CAUSE OF DEATH	
361. PLACE OF DEATH		362. DATE OF DEATH		363. TIME OF DEATH		364. SEX OF DECEASED		365. AGE OF DECEASED		366. CAUSE OF DEATH	
367. PLACE OF DEATH		368. DATE OF DEATH		369. TIME OF DEATH		370. SEX OF DECEASED		371. AGE OF DECEASED		372. CAUSE OF DEATH	
373. PLACE OF DEATH		374. DATE OF DEATH		375. TIME OF DEATH		376. SEX OF DECEASED		377. AGE OF DECEASED		378. CAUSE OF DEATH	
379. PLACE OF DEATH		380. DATE OF DEATH		381. TIME OF DEATH		382. SEX OF DECEASED		383. AGE OF DECEASED		384. CAUSE OF DEATH	
385. PLACE OF DEATH		386. DATE OF DEATH		387. TIME OF DEATH		388. SEX OF DECEASED		389. AGE OF DECEASED		390. CAUSE OF DEATH	
391. PLACE OF DEATH		392. DATE OF DEATH		393. TIME OF DEATH		394. SEX OF DECEASED		395. AGE OF DECEASED		396. CAUSE OF DEATH	
397. PLACE OF DEATH		398. DATE OF DEATH		399. TIME OF DEATH		400. SEX OF DECEASED		401. AGE OF DECEASED		402. CAUSE OF DEATH	
403. PLACE OF DEATH		404. DATE OF DEATH		405. TIME OF DEATH		406. SEX OF DECEASED		407. AGE OF DECEASED		408. CAUSE OF DEATH	
409. PLACE OF DEATH		410. DATE OF DEATH		411. TIME OF DEATH		412. SEX OF DECEASED		413. AGE OF DECEASED		414. CAUSE OF DEATH	
415. PLACE OF DEATH		416. DATE OF DEATH		417. TIME OF DEATH		418. SEX OF DECEASED		419. AGE OF DECEASED		420. CAUSE OF DEATH	
421. PLACE OF DEATH		422. DATE OF DEATH		423. TIME OF DEATH		424. SEX OF DECEASED		425. AGE OF DECEASED		426. CAUSE OF DEATH	
427. PLACE OF DEATH		428. DATE OF DEATH		429. TIME OF DEATH		430. SEX OF DECEASED		431. AGE OF DECEASED		432. CAUSE OF DEATH	
433. PLACE OF DEATH		434. DATE OF DEATH		435. TIME OF DEATH		436. SEX OF DECEASED		437. AGE OF DECEASED		438. CAUSE OF DEATH	
439. PLACE OF DEATH		440. DATE OF DEATH		441. TIME OF DEATH		442. SEX OF DECEASED		443. AGE OF DECEASED		444. CAUSE OF DEATH	
445. PLACE OF DEATH		446. DATE OF DEATH		447. TIME OF DEATH		448. SEX OF DECEASED		449. AGE OF DECEASED		450. CAUSE OF DEATH	
451. PLACE OF DEATH		452. DATE OF DEATH		453. TIME OF DEATH		454. SEX OF DECEASED		455. AGE OF DECEASED		456. CAUSE OF DEATH	
457. PLACE OF DEATH		458. DATE OF DEATH		459. TIME OF DEATH		460. SEX OF DECEASED		461. AGE OF DECEASED		462. CAUSE OF DEATH	
463. PLACE OF DEATH		464. DATE OF DEATH		465. TIME OF DEATH		466. SEX OF DECEASED		467. AGE OF DECEASED		468. CAUSE OF DEATH	
469. PLACE OF DEATH		470. DATE OF DEATH		471. TIME OF DEATH		472. SEX OF DECEASED		473. AGE OF DECEASED		474. CAUSE OF DEATH	
475. PLACE OF DEATH		476. DATE OF DEATH		477. TIME OF DEATH		478. SEX OF DECEASED		479. AGE OF DECEASED		480. CAUSE OF DEATH	
481. PLACE OF DEATH		482. DATE OF DEATH		483. TIME OF DEATH		484. SEX OF DECEASED		485. AGE OF DECEASED		486. CAUSE OF DEATH	
487. PLACE OF DEATH		488. DATE OF DEATH		489. TIME OF DEATH		490. SEX OF DECEASED		491. AGE OF DECEASED		492. CAUSE OF DEATH	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7633

CERTIFICATE OF DEATH

07590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATAPSCO PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 227 Bishop AVE		d. STREET ADDRESS 1227 Bishop AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK Walter Gibson		4. DATE OF DEATH Month Day Year 7 - 24 1960	
5. SEX Male	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 16 - 1906
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPOTEE		10b. KIND OF BUSINESS OR INDUSTRY CLEANERS	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES GIBSON		14. MOTHER'S MAIDEN NAME ROSA GOSBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. WIFE	
17. INFORMANT WIFE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension & Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 18 , 19 60 , to July 24 , 19 60 , that I last saw the deceased alive on July 24 , 19 60 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas. L. Ball Jr. M.D.		ADDRESS (Street, city or town, state) Lithicum, Md. DATE SIGNED 7/24/60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-27-60	22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem	22d. LOCATION (City, town, or county) (State) ANNE ARUNDEL CO
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson ADDRESS 1000 Bonetty ave		24a. REC'D BY REGISTRAR JUL 29 '60	24b. REGISTRAR'S SIGNATURE Walter S. Hatcher

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>		<p>TIME OF DEATH</p>		<p>PLACE OF DEATH</p>		<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>		<p>RELIGION</p>		<p>USUAL RESIDENCE</p>		<p>PRESENT RESIDENCE</p>		<p>DATE OF ENTRY INTO STATE</p>		<p>DATE OF ENTRY INTO COUNTRY</p>		<p>DATE OF ENTRY INTO CITY</p>		<p>DATE OF ENTRY INTO DISTRICT</p>		<p>DATE OF ENTRY INTO PARISH</p>		<p>DATE OF ENTRY INTO CHURCH</p>		<p>DATE OF ENTRY INTO BURIAL</p>		<p>DATE OF ENTRY INTO INTERMENT</p>		<p>DATE OF ENTRY INTO CREMATION</p>		<p>DATE OF ENTRY INTO OTHER</p>	
<p>John Doe</p>		<p>45</p>		<p>Male</p>		<p>White</p>		<p>1880</p>		<p>1925</p>		<p>10:00 AM</p>		<p>Home</p>		<p>Heart Disease</p>		<p>Natural</p>		<p>High School</p>		<p>Teacher</p>		<p>Protestant</p>		<p>123 Main St</p>		<p>123 Main St</p>		<p>1900</p>		<p>1900</p>		<p>1900</p>		<p>1900</p>		<p>1900</p>		<p>1900</p>									

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

7591

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07591

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 183 Janice Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gerard Middle - - - Last GORMLEY				4. DATE OF DEATH Month July Day 28 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27, 1960		9. AGE (In years last birthday) yrs. 1 7 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Donald Richard Gormley				14. MOTHER'S MAIDEN NAME Betty Jo Schwieterman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 27, 1960 to July 28, 1960 , that (I) was last saw the deceased alive on July 28, 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Niel H. Sims				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 95 Cathedral St., Annapolis, Md.		22b. DATE SIGNED 7/29/60	
22c. PHYSICIAN'S NAME (Type) Niel H. Sims							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-2-1960		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Va	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor Sims				25a. REC'D BY REGISTRAR DATE AUG 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2063263XV1

07501

CERTIFICATE OF DEATH

1951

(M)

Name of deceased		Date of death	
John Doe		Jan 15, 1951	
Age		Sex	
65 years		Male	
Marital status		Cause of death	
Married		Heart disease	
Place of death		Occupation	
Home		Farmer	
Signature of physician		Signature of registrar	
[Signature]		[Signature]	
Date of registration		Place of registration	
Jan 16, 1951		City of New York	

(1)

Name of informant		Relationship to deceased	
John Doe		Son	
Address of informant		City of New York	
[Address]		[City]	
Signature of informant		Date of completion	
[Signature]		Jan 16, 1951	
Official use		Remarks	
[Official use]		[Remarks]	

1
FOR STATE
HEALTH DEPT.

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4707 Wrenwood Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JAMES C. GREEN			4. DATE OF DEATH July 4 19 60			5. SEX Male			6. COLOR OR RACE Colored		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH Dec. 11, 1929			9. AGE (in years last birthday) 30 yrs.			10. IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Social Security			11. BIRTHPLACE (State or foreign country) Balto., Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joshua Green						14. MOTHER'S MAIDEN NAME Mary Green					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Korean						16. SOCIAL SECURITY NO. Margaret B. Green					
17. INFORMANT Margaret B. Green						Address 4707 Wrenwood Street Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and Arteriosclerotic Heart Disease with Total Occlusion of Right Coronary Artery and One Branch of Left Coronary Artery, and Old Myocardial Infarction. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 420.1 (c) xxxxx DUE TO (c) Myocardial Infarction.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. DATE SIGNED 7/5/60											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/8/60		22c. NAME OF CEMETERY OR CREMATORY Balto National Cemetery		22d. LOCATION (City, town, or country) (State) Balto., Md.			
23. FUNERAL DIRECTOR Halstead & March ADDRESS 928 E. North Ave.						24a. REC'D BY REGISTRAR 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

07592

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7634

CERTIFICATE OF DEATH

Reg. Dist. No. 07593

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>X</u> b. COUNTY <u>Danville</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Danville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>107 - W. 11th Ave</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Howard</u> Last <u>Hammond</u>			4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1903</u>		9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck - Chauffeur - Armour -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AA Co. Ind -</u>		11. BIRTHPLACE (State or foreign country) <u>AA Co. Ind -</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AA Co. Ind -</u>			13. FATHER'S NAME <u>Rezin Hammond</u>		
14. MOTHER'S MAIDEN NAME <u>Margaret Greenstein</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>24-18-1311</u>			17. INFORMANT <u>Madeline Hammond - same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chirrosis of liver</u> DUE TO (c) <u>Diabetes</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u> <u>18 mo.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>7/9/60</u> , 19 <u>40</u> , to <u>7/9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/9/60</u> , 19 <u> </u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Chas. L. Ball Jr</u> M.D.			ADDRESS (Street, city or town, state) <u>Linthicum - Md.</u> DATE SIGNED <u>7/9/60</u>		
PHYSICIAN'S NAME (Type) <u>Chas. L. Ball Jr</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>7-13-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	22d. LOCATION (City, town, or county) (State) <u>Balto</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Ball - 130 E Fort Ave</u>			ADDRESS <u>130 E Fort Ave</u>		24a. REC'D BY REGISTRAR DATE <u>7/13/60</u>
			24b. REGISTRAR'S SIGNATURE <u>Wm. L. Hall</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RECORDS AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7593

07594

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arthur		First Lee Middle Hardesty Last		4. DATE OF DEATH Month July Day 18 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 9, 1917	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months 42 Days 18 Hours 19 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLANT FOREMAN				10b. KIND OF BUSINESS OR INDUSTRY Bottled Gases		11. BIRTHPLACE (State or foreign country) Maryland, Galesville	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME THOMAS ALVIN Hardesty				14. MOTHER'S MAIDEN NAME Christine A. Hardesty Galesville			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-26-4950		17. INFORMANT Ruth L. Hardesty Galesville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen. carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of pancreas DUE TO (c) 197X							INTERVAL BETWEEN ONSET AND DEATH 7 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1960 to July 18, 1960 , that (I) may saw the deceased alive on July 18, 1960 , and that death occurred at 8:50 PM from the causes and on the date stated above.							
22a. SIGNATURE S. Borssuck M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 8:50 P.		22b. DATE SIGNED 7/19/60	
22c. PHYSICIAN'S NAME (Type) Samuel Borssuck				22d. ADDRESS Amos Garrett Blvd., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/21/60		23c. NAME OF CEMETERY OR CREMATORY Woodfield		23d. LOCATION (City, town, or county) (State) Galesville Md	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard C. Hardesty Galesville Md.				25a. REC'D BY REGISTRAR JUL 26 '60		25b. REGISTRAR'S SIGNATURE Christine S. Kenna	

MEDICAL CERTIFICATION

1503

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

VS A15 (4)
15M 9/55

Item 7-22-60 File 206 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
7594										
CERTIFICATE OF DEATH										
Reg. Dist. No. 07595										
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Homewood Convalescent Home</u>					d. STREET ADDRESS <u>4 Randall Court</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mattie V. Hardesty</u>					4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1883</u>		9. AGE (In years last birthday) yrs. <u>77</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Wm E. Hardesty</u>					14. MOTHER'S MAIDEN NAME <u>Martha Chaney</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>902.7</u>		17. INFORMANT <u>Mrs. Mae L. Hardesty</u>			Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>902.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture pubis</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off of chair at home</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> p. m. <u>6-10</u> <u>1960</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Annapolis AA Md</u>		
21. I certify that I attended the deceased from <u>June 5, 1960</u> to <u>July 9, 1960</u> , that I last saw the deceased alive on <u>July 8, 1960</u> , and that death occurred at <u>6:02</u> M. from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Emily H. Wilson</u>					ADDRESS (Street, city or town, state) <u>Letham, Md.</u>			DATE SIGNED <u>7-11-60</u>		
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Traces Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>					ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7635

CERTIFICATE OF DEATH

Reg. Dist. No. 02596

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital				d. STREET ADDRESS 7006-C Antelak Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle N. Last HARPER				4. DATE OF DEATH Month July Day 13 Year 19 60			
5. SEX MALE		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 July 1960	
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Emanuel Harper				14. MOTHER'S MAIDEN NAME Evelyn L. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		INFORMANT Mr. Emanuel Harper, 7006 C Antelak St, Ft Meade Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extreme prematurity DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 July , 19 60 , to 13 July , 19 60 , that I last saw the deceased alive on 13 July , 19 60 , and that death occurred at 7:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fort George G. Meade, Md DATE SIGNED 13 July 60							
ACTUAL SIGNATURE Wilbur H. Miller M.D.							
PHYSICIAN'S NAME (Type) WILBUR H. MILLER, JR., CAPT, MC U. S. Army Hospital, Ft Geo G. Meade, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 13 Jul 60		22c. NAME OF CEMETERY OR CREMATORY Laboratory, U.S. Army Hospital, Ft Geo G Meade, Maryland		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B.M. Ellis Capt., MSC, USAH, FGGM				24a. REC'D BY REGISTRAR Jul 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kincaid	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7636 CERTIFICATE OF DEATH

07598

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West River Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West River</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Harvey</u> Middle <u>Harvey</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1960</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1915</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR: Months <u>44</u> Days <u>44</u> Hours <u>44</u> Min. <u>44</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Snack driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Const</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Harvey</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Peters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-241019</u>	
17. INFORMANT <u>Elizabeth Harvey</u> Address <u>West River Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Right Inferior</u> <u>160.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarct</u> DUE TO (c) <u>5 hr</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1960</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 19, 1959</u> to <u>July 8, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 1, 1960</u> , and that death occurred at <u>3:15 P. M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>RL. Richardson</u>		22b. DATE SIGNED <u>7/11/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>RL. Richardson</u>		22d. ADDRESS <u>110-2014 St. Anns Rd, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-12-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>House of prayer</u>		23d. LOCATION (City, town, or county) (State) <u>West River Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Anna Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arbuthnot S. Hume</u>		DATE <u>JUL 13 '60</u>	

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STATE OF NEW YORK

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(S)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																			
7595 CERTIFICATE OF DEATH 07599																			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					c. LENGTH OF STAY IN 1b 1 day					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital					d. STREET ADDRESS 8 Kirbys Lane					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last HENSON					4. DATE OF DEATH Month Day Year July 30 19 60														
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1960		9. AGE (In years last birthday) yrs. 2 50		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Donald B. Henson					14. MOTHER'S MAIDEN NAME Miriam Makell														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Donald Henson Annapolis					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythras Reticular Fetalis - Pneumia DUE TO 770.0 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH Intrauterine									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from July 30, 1960 to July 30, 1960 , that (I) see last saw the deceased alive on July 30, 1960 and that death occurred at 11:00 P.M. from the causes and on the date stated above.										22a. SIGNATURE Philip Puscare					22b. DATE SIGNED 8/1/60				
22c. PHYSICIAN'S NAME (Type) Philip Puscare					22d. ADDRESS 95 LaBreda St Annapolis Md														
23a. BURIAL, CREMATION, REMOVAL (Specify) Aug 2/60					23b. DATE THEREOF Aug 2/60					23c. NAME OF CEMETERY OR CREMATORY Broadneck					23d. LOCATION (City, town, or county) (State) St Margarets AA Md				
24. FUNERAL DIRECTOR'S SIGNATURE Amel A. Johnson					ADDRESS Annapolis					25a. REC'D BY REGISTRAR DATE AUG 5 '60					25b. REGISTRAR'S SIGNATURE Arthur S. Knaus				

2063201XV4

07500

CONTINUED OF DATA

07500



Date	Time	Location	Remarks	Remarks
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000
1950	10:00	10000	10000	10000



1
FOR STATE
HEALTH DEPT.

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07592

1. PLACE OF DEATH a. COUNTY <i>D.C.</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis P.O.</i> c. LENGTH OF STAY IN lb <i>3 days.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Highland Beach.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>47X-3</i> d. STREET ADDRESS <i>1852 - T Street N.W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Essie Burrell Howley</i> First Middle Last <i>Essie Burrell Howley</i>		4. DATE OF DEATH Month Day Year <i>July 30 1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/24/82</i> AGE (In years last birthday) <i>77</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	
13. FATHER'S NAME <i>Henry Burrell</i>		14. MOTHER'S MAIDEN NAME <i>Evelyn Page</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO (b) <i>General Arterio Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i> <i>?</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Eustace H. Faubert</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>EUSTACE H. FAUBERT M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>7/30/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/4/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Nat'l. Harmony Park Cem.</i>		22d. LOCATION (City, town, or country) (State) <i>Maryland</i>	
23. FUNERAL DIRECTOR <i>Robert H. Jones</i> ADDRESS <i>1820 - 9th St. N.W. WASH. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 2 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fenn</i>	

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS IS TO CERTIFY THAT



DEATH OF _____

DATE OF DEATH _____

PLACE OF DEATH _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7619

CERTIFICATE OF DEATH

Reg. Dist. No. 07600

1. PLACE OF DEATH a. COUNTY <i>AA.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>ANNE</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ORCHARD BE.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANNE</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1017 Belvedere Pl.</i>				d. STREET ADDRESS <i>1017 Belvedere Pl.</i>			
3. NAME OF DECEASED (Type or print) First <i>Florence</i> Middle <i>E.</i> Last <i>Hood</i>				4. DATE OF DEATH Month <i>JULY</i> Day <i>28</i> Year <i>1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-17-92</i>	9. AGE (In years last birthday) <i>67</i> yrs.	IF UNDER 1 YEAR Months <i>6</i> Days <i>27</i> Hours <i>15</i> Min.	IF UNDER 24 HRS. Months <i>2</i> Days <i>24</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>Federick Gleason</i>				14. MOTHER'S MAIDEN NAME <i>Kathryn Gale</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>1-1-1-1-1-1-1-1-1-1</i>		17. INFORMANT <i>Family - Same</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Broncho-pneumonia</i> DUE TO (b) <i>Massive Cerebral Hemorrhage</i> DUE TO (c) <i>Cerebral Arteriosclerosis & Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <i>24 HRS</i> <i>2 months</i> <i>8 YRS.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>July 26</i> , 1960, to <i>July 28</i> , 1960, that I last saw the deceased alive on <i>July 28</i> , 1960, and that death occurred at <i>1:45 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Arthur Lankford Jr.</i>				ADDRESS (Street, city or town, state) <i>Mountain Road Pasadena, Maryland</i>			
PHYSICIAN'S NAME (Type) <i>ARTHUR LANKFORD JR</i>				DATE SIGNED <i>7-28-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>7-31-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Smith Valley</i>		22d. LOCATION (City, town, or county) (State) <i>Wilkesville, N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Long - 130 E. Fort Ave.</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 29 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G267 7-28-60 et

7638

CERTIFICATE OF DEATH

Reg. Dist. No.

07601

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 M. 21 Day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1308 Linden Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Nola Middle Johnson Last Johnson		4. DATE OF DEATH Month 7 Day 21 Year 1960		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 26, 1911		9. AGE (In years last birthday) yrs. 49		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William L. Thomas						14. MOTHER'S MAIDEN NAME Etiza Burke									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -----				17. INFORMANT Hospital Records Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyonephrosis DUE TO (c) Carcinoma of Urinary Bladder														INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----											
20c. TIME OF INJURY Hour o. m. p. m. ----- Month, Day, Year ----- 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----		(State) -----			
21. I certify that I attended the deceased from 6/1 , 19 60 to 7/21 , 19 60 , that I last saw the deceased alive on 7/21 , 19 60 , and that death occurred at 6:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 7/21/60 ACTUAL SIGNATURE L. Benedict M.D. Crownsville State Hospital, Md. 7/21/60 PHYSICIAN'S NAME (Type) L. Benedict, M. D.															
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial				22b. DATE THEREOF 7/23/60		22c. NAME OF CEMETERY OR CREMATORY Richards Cem.				22d. LOCATION (City, town, or county) (State) Easton Md.					
23. FUNERAL DIRECTOR'S SIGNATURE James B. Obwell						ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE III 25 '60		24b. REGISTRAR'S SIGNATURE Charles L. Knaus					

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7596

07602

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>F.</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 14, 1910</u>	
9. AGE (In years lost birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Industrial Relations Industrial Relations</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Miss our</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Charles B. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Lena Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Dorothy Moreland Jones</u>				Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEMORRHAGIC PANCREATITIS</u> 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>14 HOURS</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>December 1959</u> to <u>July 14</u> 19 <u>60</u> , that (I) <u> </u> last saw the deceased alive on <u>July 14, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward S. Beck</u>				22b. DATE <u>5:00 A.M.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>7/15/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>				22d. ADDRESS <u>71 Franklin St., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 18-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sins</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>JUL 18 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

00000

OFFICE OF THE
SHERIFF

1900

(M)

(A)

(C)

RECEIVED

1900

CERTIFICATE OF DEATH

Reg. Dist. No. 07603

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
c. LENGTH OF STAY IN 1b <u>30yrs</u>		d. STREET ADDRESS <u>916 Smithville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>916 Smithville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>Tyler</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>19 60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23-1891</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Aaron Tyler</u>	
14. MOTHER'S MAIDEN NAME <u>Harriett Scales</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>ANAPOLIS-Md. 916 Smithville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>792X</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>—</u> (c) DUE TO <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-4-59</u> , 19 <u>59</u> to <u>7-1-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-11-60</u> , 19 <u>60</u> , and that death occurred at <u>11:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. E. Hicks</u>		DATE SIGNED <u>7-5-60</u>	
PHYSICIAN'S NAME (Type) <u>A. J. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Cocke Street</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-5-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks</u> ADDRESS <u>ANNAPOLIS-Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u> DATE <u>JUL 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

Page 4
The low requires that the death certificate be executed within 72 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECORDS OF THE

OFFICE OF THE

SECRETARY OF THE

NAVY DEPARTMENT

WASHINGTON

1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7598

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07604

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. LENGTH OF STAY IN 1b X d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena - Rivera Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 248 Wendover Road	
3. NAME OF DECEASED (Type or print) First Donald Middle G. Last KENT		4. DATE OF DEATH Month July Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1909
9. AGE (In years last birthday) 51		10. IF UNDER 1 YEAR 51 yrs. Months 51 Days 51 Hours 51 Min. 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Comfort Spring Corp.	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Kent		14. MOTHER'S MAIDEN NAME Elizabeth Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-9456	
17. INFORMANT Mrs. Louise E. Kent-248 Wendover Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE ANTERIOR MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) CORONARY THROMBOSIS DUE TO (c) 2 HRS.		INTERVAL BETWEEN ONSET AND DEATH 2 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1960 to July 31, 1960 that (I) (we) last saw the deceased alive on July 31, 1960 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Arthur Lankford Jr.		22b. DATE SIGNED 8-1-60	
22c. PHYSICIAN'S NAME (Type) Arthur E. Lankford, Jr.		22d. ADDRESS Mountain Road, Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/4/60	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park Cem.		23d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor		25a. REC'D BY REGISTRAR Aug 3 '60	
ADDRESS Baltimore-17, Md.		25b. REGISTRAR'S SIGNATURE William J. Tichenor	

1000

WEST VIRGINIA DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Name of Deceased: *John A. Smith*
Age: *45* Sex: *M* Race: *W*

Residence: *123 Main St., Charleston, W. Va.*

Place of Death: *General Hospital*

Date of Death: *May 15, 1900*

Time of Death: *10:30 A.M.*

Signature of Physician: *Dr. J. H. Smith*

Signature of Registrar: *Wm. H. Smith*

Signature of Coroner: *John A. Smith*

Signature of Burial Officer: *John A. Smith*

Signature of Minister: *John A. Smith*

Signature of Undertaker: *John A. Smith*

Signature of Witness: *John A. Smith*

Signature of Witness: *John A. Smith*

Signature of Witness: *John A. Smith*

Signature of Witness: *John A. Smith*

Signature of Witness: *John A. Smith*

Signature of Witness: *John A. Smith*

Signature of Witness: *John A. Smith*

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>128 Market St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>A. Kramer Jr.</u> Last <u></u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3^d 1918</u>
9. AGE (in years last birthday) yrs. <u>41</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Yachts</u>	
13. BIRTHPLACE (State or foreign country) <u>Portland Oregon</u>		14. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. FATHER'S NAME <u>Andrew A. Kramer Sr.</u>		16. MOTHER'S MAIDEN NAME <u>Mary E. Preller</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>		18. SOCIAL SECURITY NO. <u>Nancy C. Kramer</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malignant Hypertension</u> DUE TO <u>171</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>59</u> , to <u>2-14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-14</u> , 19 <u>60</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>6 Shaw St. Annapolis, Md.</u>	
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		DATE SIGNED <u>7/16/60</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		ADDRESS <u>6 Shaw St. Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JUL 18 '60</u>			

VS A15 (4)
15M 9/55

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7600

CERTIFICATE OF DEATH

07606

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 34 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle LARKIN Last LARKIN				4. DATE OF DEATH Month July Day 24 Year 19 60			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10 1897	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min. 63	IF UNDER 24 HRS. Months 63 Days 63 Hours 63 Min. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboreh		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Horace Larkin			14. MOTHER'S MAIDEN NAME Mina Johnson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-0940		17. INFORMANT Garfield Larkins Address Odenton Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 33 days DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 33 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 20, 19 60 , to July 23, 19 60 , that (I) was last saw the deceased alive on July 23, 19 60 , and that death occurred at 6:45 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Edward S. Beck				22b. DATE 7/25/60		22c. PHYSICIAN'S NAME (Type) Edward S. Beck	
23a. BURIAL, CREMATION, REMOVAL (Specify) July 27/60		23b. DATE THEREOF July 27/60		23c. NAME OF CEMETERY OR CREMATORY Faulk's		23d. LOCATION (City, town, or county) (State) Odenton A.A. Ind	
24. FUNERAL DIRECTOR'S SIGNATURE Amel A. Johnson				25a. REG. BY REGISTRAR JUL 27 60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

07000



CERTIFICATE OF DEATH

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7601
7601
CERTIFICATE OF DEATH

Reg. Dist. No. 07607

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospt.</u>		d. STREET ADDRESS <u>Highland Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>P.</u> Last <u>Lebelle</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1909</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Analysis</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Paul Lebelle</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>420-1</u>		17. INFORMANT <u>Lucille M. Lebelle</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary calcification</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery Disease</u> DUE TO (c) <u>37 yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>DOA</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> to <u>7-8-1960</u> , that I last saw the deceased alive on <u>7-6-60</u> , 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		ADDRESS (Street, city or town, state) <u>121 Cathedral St Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		DATE SIGNED <u>7-8-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>July 11, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7602

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07608

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ann e Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Davidsonville d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ernest RAY LONG		4. DATE OF DEATH Month Day Year July 4 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Fireman		10b. KIND OF BUSINESS OR INDUSTRY US Gov	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Henry Long		14. MOTHER'S MAIDEN NAME Arabella Sands	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 205-03-1365	
17. INFORMANT Mae M. Long- Wife- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary embolus DUE TO 1 mo (c) Carcinoma of Bladder 2 yrs		INTERVAL BETWEEN ONSET AND DEATH 6 hrs 1 mo 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 4, 1960 to July 4, 1960 , that (I) was last saw the deceased alive on July 4, 1960 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Edwin Davis, Jr. M.D.		22b. DATE SIGNED 7-4-60	
22c. PHYSICIAN'S NAME (Type) Edwin Davis, Jr.		22d. ADDRESS 98 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 8, 1960	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JUL 11 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Hines			

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1900

(M)



(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7639

CERTIFICATE OF DEATH

Reg. Dist. No.

07609

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corrocollan Manor, 35</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corrocollan Manor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Manor Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Isaac Winfield Machin</u> First Middle Last		4. DATE OF DEATH <u>7-28-60</u> 19- Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	9. AGE (In years last birthday) <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son Winfield Machin</u> Address <u>Aban</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C. V. Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , 19____, to <u>1960</u> , 19____, that I last saw the deceased alive on <u>7-27-60</u> 19____, and that death occurred at <u>1:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Halbur</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>7-28-60</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Halbur</u>		<u>md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8-1-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Benavides</u> ADDRESS <u>Severna Park</u>		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

07610
Reg. Dist. No.

Reg. Dist. No.

VS A15 (4)
15M 9/58

100000

CERTIFICATE OF DEATH

100000



[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Registrar" are faintly visible.]



CERTIFICATE OF DEATH

07611

Reg. Dist. No.

7640

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAVIDSONVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAVIDSONVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Lidwina First Mayr Middle Mayr Last				4. DATE OF DEATH July 31 Month July Day 31 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1873	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Months 7 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clemark Greisl				14. MOTHER'S MAIDEN NAME (Unknown) Brugger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Thomas E. Mayr- Son- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular DUE TO (c) disease and senility						INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from July 30, 1960 , to July 31, 1960 , that I last saw the deceased alive on July 31, 1960 , and that death occurred at 10:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sylvia M. Linn				ADDRESS (Street, city or town, state) RFD #1, Box 277-M, Edgewater, Md.			
PHYSICIAN'S NAME (Type) Sylvia M. Linn				DATE SIGNED 7-31-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF August 3, 60	22c. NAME OF CEMETERY OR CREMATORY Our Lady of Sorrows		22d. LOCATION (City, town, or county) Owensville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR DATE AUG 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
7641										
CERTIFICATE OF DEATH										
Reg. Dist. No. 07612										
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade			c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			13X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION United States Army Hospital					d. STREET ADDRESS 212-A Gorman Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES BLAIN METCALF					4. DATE OF DEATH Month Day Year July 25 19 60					
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 July 60		9. AGE (In years last birthday) yrs. 10		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A			10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Llewellyn Metcalf					14. MOTHER'S MAIDEN NAME Romana Swift					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Father 212 A Gorman Rd Laurel, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.5 Immaturity DUE TO (b) Subarachnoid and intraventricular hemorrhage Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH Since Birth recent moderate		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 15 July 19 60, to 25 July 19 60, that I last saw the deceased alive on 25 July 19 60, and that death occurred at 9:25 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED WILBUR H. MILLER, JR., Capt., M.C. USA Hosp Ft Geo G Meade, Md 25 July 60										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 7-27-60		22c. NAME OF CEMETERY OR CREMATORY ULYSSES CEM.			22d. LOCATION (City, town, or county) (State) ULYSSES PA.		
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Miller					ADDRESS Gorman Rd		24a. REC'D BY REGISTRAR DATE JUL 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

2050283X2

CONFIDENTIAL

SECRET

DECLARATION OF DEATH

1-2-50 11-22-52 11-22-52

7642

CERTIFICATE OF DEATH

07613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owens Beach</i>		c. LENGTH OF STAY IN 1b <i>3 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R F D # 1 Deale Md</i>		d. STREET ADDRESS <i>3828 34th st</i>	
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>Elizabeth</i> Last <i>Miller</i>		4. DATE OF DEATH Month <i>July</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 27, 1863</i>
9. AGE (In years last birthday) <i>96</i> yrs.		IF UNDER 1 YEAR Months <i>2</i> Days <i>20</i> Hours <i>0</i> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Ohio</i>
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>Kennedy Evans</i>	
14. MOTHER'S MAIDEN NAME <i>Nancy Crumb</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Lucy Bon Durant Mt Rainier Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary insufficiency</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>20 yrs.</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>12 July</i> , 19 <i>60</i> , to <i>13 July</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>13 July</i> , 19 <i>60</i> , and that death occurred at <i>11:40</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R B Sasser</i>		DATE SIGNED <i>13 July 1960</i>	
PHYSICIAN'S NAME (Type) <i>R B Sasser</i>		ADDRESS (Street, city or town, state) <i>Upper Marlboro Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial, Removal</i>		22b. DATE THEREOF <i>7/16/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapple Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Newcomerstown, Ohio</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR <i>JUL 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles L. Hanna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7643

07614

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	c. LENGTH OF STAY IN 1b <u>9 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u> <u>1130-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>		d. STREET ADDRESS <u>6407 Kolb Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Miller</u> Last <u></u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-1893</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Wesley-D.P.W.-Prince George Co.Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General debility and decubitus ulcers.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>? yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 25,</u> <u>1960</u> to <u>July 4,</u> <u>1960</u> , that (I) (was) lost saw the deceased alive on <u>July 2,</u> <u>1960</u> , and that death occurred at <u>3A</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>James M. Pair</u>		22b. DATE SIGNED <u>July 4, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u>		22d. ADDRESS <u>400 N. Carrollton Avenue Balto. 23, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-7-60</u>	23b. DATE THEREOF <u>7-7-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Ch. Am</u>	23d. LOCATION (City, town, or county) (State) <u>Croon Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington & Son</u> <u>4925 - D Lane Am N.E.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 8 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>

1948

RECEIVED

1948

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[Handwritten signature]

1948

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07615

Reg. Dist. No.

7604

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Ad. Co.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b <i>10</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Ad. Co.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Ad. General Hospital</i>		d. STREET ADDRESS <i>79 Spa Road</i>	
4. NAME OF DECEASED (Type or print) <i>Anthony Molbrey</i>		4. DATE OF DEATH Month <i>7</i> Day <i>6</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-7-1960</i>
9. AGE (In years last birthday) <i>5</i> yrs.		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>5</i> Hours <i>5</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Molbrey</i>		14. MOTHER'S MAIDEN NAME <i>Mary Clendenin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Mary Clendenin 79 Spa Rd</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>asphyxia</i> DUE TO <i>924.0</i> Conditions, if any, which gave rise to immediate cause (b) [a], stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Sudden</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Choked to death by overeating</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>7-6</i> p. m. <i>1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>A.A.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhardt</i>		DATE SIGNED <i>7-6-60</i>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-8-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hall</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		24a. REC'D BY REGISTRAR <i>Jul 7-4 '60</i>	
ADDRESS <i>Annapolis</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7644

CERTIFICATE OF DEATH

Reg. Dist. No.

07616

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 7 mo. 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount d. STREET ADDRESS 802-58th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert S. Nichols				4. DATE OF DEATH Month Day Year 7 5 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1876	
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Texas				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert S. Nichols				14. MOTHER'S MAIDEN NAME Amanda ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Senile Brain Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Hour a. m. p. m. ----- Month, Day, Year ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 11/19 , 19 57 , to 7/5 , 19 60 , that I last saw the deceased alive on 7/5 , 19 60 , and that death occurred at 8:00A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissman				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.		DATE SIGNED 7/5/60	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				Crownsville State Hospital, Md.		7/5/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/9/60		22c. NAME OF CEMETERY Nat'l. Harmony Mem.		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert P. McLine				ADDRESS 1820-9th St. N.W.		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7645

CERTIFICATE OF DEATH

Reg. Dist. No. 07617

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
f. STREET ADDRESS <u>604 W. Fayette Street</u> 1				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Parker</u>				4. DATE OF DEATH Month Day Year <u>July 25, 1960</u> 19			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1864</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Rainey-Baltimore D.P.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease with</u> <u>423-1</u> DUE TO <u>chronic brain syndrome.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Many yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 8,</u> 19 <u>60</u> , to <u>July 25,</u> 19 <u>60</u> , that I last saw the deceased alive on <u>July 23,</u> 19 <u>60</u> , and that death occurred at <u>3 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James M. Pair</u> M.D. <u>400 N. Carrollton Avenue</u> <u>7-25-1960</u> <u>Baltimore 23, Maryland</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles K. Law</u> <u>802 Madison Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles K. Law</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7605

07618

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elvaton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 363 Brookwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle F Last PERINA, Sr.				4. DATE OF DEATH Month July Day 6 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1900		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Packer & House		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Perina			14. MOTHER'S MAIDEN NAME Nichle				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-01-9826		17. INFORMANT Edward Perina JR Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Coronary artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. & Pericarditis (b) 420-1 (c) 4 days						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 2, 1960 , to July 5, 1960 , that (I) (we) last saw the deceased alive on July 5, 1960 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/6/60	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 8-60		23c. NAME OF CEMETERY OR CREMATORY Glen Burne Cemetery		23d. LOCATION (City, town, or county) (State) Glen Burne Md	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard R. Fink				25a. REC'D BY REGISTRAR DATE JUL 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

11871

CERTIFICATE OF DEATH

11871



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7646

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore/25 - A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3504 Fourth Street Baltimore 25</u>	
c. LENGTH OF STAY IN 1b <u>10 hrs.</u>		d. STREET ADDRESS <u>3504 Fourth Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>601 Sixth Ave and Ritchie Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elmoden Pitcock</u>		4. DATE OF DEATH <u>July 18th.</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/28/14</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Winchester, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmoden Pitcock</u>		14. MOTHER'S MAIDEN NAME <u>Edna Avery</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes (Marines) 1943</u>		16. SOCIAL SECURITY NO. <u>066-14-4399</u>	
17. INFORMANT <u>Mrs. Nora Pitcock</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420-1</u> (c), stating the underlying cause lost. (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/18/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Winchester, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

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TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundle, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 218 Wicklow Ave.				d. STREET ADDRESS Same			
3. NAME OF DECEASED (Type or print) First Middle Last Rose Lee Ramsburg				4. DATE OF DEATH Month Day Year 7 20 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/28/68 1869	
9. AGE (In years last birthday) 92 9/12 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Louden Co., Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME John Schaefer				14. MOTHER'S MAIDEN NAME Darcus Jane ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Lucy Lahan (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO				INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-60		22c. NAME OF CEMETERY OR CREMATORY New Catholic Cem.		22d. LOCATION (City, town, or county) (State) Baltimore MD	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home				ADDRESS 1306 Fort Ave		24a. REC'D BY REGISTRAR JUL 22 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1
FOR STATE
HEALTH DEPT.

7648

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville	
3. NAME OF DECEASED (Type or print) First John Middle David Last Rice		4. DATE OF DEATH Month July Day 27 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1914
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY US Gov't	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William John Rice		14. MOTHER'S MAIDEN NAME Clara F. Donaldson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs Jessie Rice, Same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suicide by voluntary inhalation of carbon DUE TO (b) monoxide Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) By connecting one end of rubber hose to exhaust exhaust pipe and the other end to the front seat	
20c. TIME OF INJURY Month, Day, Year Unknown p. m. 7/27/60		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hog Road	
20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Millersville, A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/27/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 1960	
22c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial		22d. LOCATION (City, town, or county) (State) Millersville, AA Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		ADDRESS Glen Burnie, Md.	
24a. REC'D BY REGISTRAR JUL 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7649

CERTIFICATE OF DEATH

Reg. Dist. No. 02622

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>5yrs. 6mos.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>Crownsville State Hospital</u>			d. STREET ADDRESS <u>03X-2</u>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Ringgold</u> Last <u>Ringgold</u>			4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/28</u>		9. AGE (In years last birthday) <u>32</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Charles Ringgold</u>			14. MOTHER'S MAIDEN NAME <u>Amelia</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>	INFORMANT <u>Hospital records</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Dec. 17, 1954</u> to <u>July 1, 1960</u> , that I lost s/he the deceased alive on <u>July 1, 1960</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Carl B. Schleifer</u> M.D.			ADDRESS (Street, city or town, state) <u>76 CROWNVILLE STATE HOSP</u> DATE SIGNED <u>July 1960</u>		
PHYSICIAN'S NAME (Type) <u>Carl B Schleifer</u>			<u>CROWNVILLE MD.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)	
<u>Burial</u>	<u>7-6-60</u>	<u>Stevenson Cem.</u>	<u>Sparks</u>	<u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jackson Funeral Home 906 Penn Ave</u>		ADDRESS	24a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

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CERTIFICATE OF DEATH

1944

NAME: Anne Arnold
RESIDENCE: Greenville
OCCUPATION: State Hospital
DATE OF DEATH: July 1, 1944
AGE: 33
SEX: Female
CAUSE OF DEATH: Charles Rindgold
PLACE OF DEATH: Hospital records
MANNER OF DEATH: Natural

Signature: [Illegible]
Date: July 1, 1944
Place: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
7650 CERTIFICATE OF DEATH											
Reg. Dist. No. 07623											
1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY <i>Pr. Geo. ✓</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade			c. LENGTH OF STAY IN 1b 27 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital					d. STREET ADDRESS 9 Laurel Mannor, Apt 1						
3. NAME OF DECEASED (Type or print) Infant First Middle Last Robinson					4. DATE OF DEATH Month Day Year July 1 19 60						
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 Jun 1960		9. AGE (In years lost birthday) yrs. 27			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A			10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John R. Robinson					14. MOTHER'S MAIDEN NAME Gladys Ann Banks						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) N/A		17. INFORMANT Address Mrs. Gladys Robinson, 9 Laurel Mannor, Laurel Md						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Immaturity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								INTERVAL BETWEEN ONSET AND DEATH Since birth			
21. I certify that I attended the deceased from 30 June 19 60 to 1 July 1960, that I last saw the deceased alive on 1 July 19 60, and that death occurred at 0845 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1 July 60											
ACTUAL SIGNATURE Wilbur H. Miller Jr. M.D.											
PHYSICIAN'S NAME (Type) WILBUR H. MILLER, JR., Capt, MC, U.S. Army Hospital, Ft Geo G. Meade, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF July 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Savage Cemetery			22d. LOCATION (City, town, or county) (State) Savage Md			
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson, Laurel, Md.					24a. REC'D BY REGISTRAR JUL 8 '60					24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

2050283XV1

CERTIFICATE OF DEATH

1900

1

Dec 3, 1900

Age of decedent

Sex

30 Nov 1900

Residence

City and State

County

Decedent's name

Place of death

Interment

Signature of physician

Signature of registrar

Signature of undertaker

Signature of witness

Signature of coroner

Signature of jury

Signature of clerk

Signature of registrar

Signature of undertaker

7651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 0268 8-2-60 et

07624

Reg. Dist. No.

FOR STATE
HEALTH-DEPT.

1. If any of the following is necessary, please
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 100. If any of the following is necessary, please

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Heights</u>		c. LENGTH OF STAY IN 1b <u>13 years</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u>		b. COUNTY <u>Same</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George John Roche</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21st</u> Year <u>1960</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/7/86</u>		9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Edna Gertrude Roche (wife)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>42061</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7/21/60</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>7-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		ADDRESS <u>1305 Fort Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u> </u>		VS. A15ME BM 2/57													

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [REDACTED]

2. SEX: [REDACTED] AGE: [REDACTED]

3. DATE OF BIRTH: [REDACTED]

4. PLACE OF BIRTH: [REDACTED]

5. OCCUPATION: [REDACTED]

6. MARITAL STATUS: [REDACTED]

7. CAUSE OF DEATH: [REDACTED]

8. MANNER OF DEATH: [REDACTED]

9. SIGNATURE OF EXAMINER: [REDACTED]

10. DATE: [REDACTED]

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7652

CERTIFICATE OF DEATH

07625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS, RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BELVOIR, CROWNSVILLE, MD.</u>		d. STREET ADDRESS <u>BELVOIR, CROWNSVILLE, MD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET BRYAN ROGERS</u>		4. DATE OF DEATH Month Day Year <u>7 18 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21-1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL BRYAN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET REMIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Archibald C. Rogers</u>	
17. INFORMANT Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC AND HYPERTENSIVE</u> DUE TO (c) <u>VASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES.</u> <u>2 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/27/1955</u> , to <u>7/18, 1960</u> , that I last saw the deceased alive on <u>6/7, 1960</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D. <u>121 CATHEDRAL ST</u>		DATE SIGNED <u>7/18/60</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		<u>ANNAPOLIS,</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-21-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNES</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Francis</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.		1925		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		MARRIAGE DATE		MARRIAGE PLACE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
JAMES H. HARRIS		MARY J. HARRIS		1900		BALTIMORE, MD.		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS TOXICITY		PREVIOUS INFECTION		PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF ASSISTANT		NAME OF ATTENDING		NAME OF WITNESS	
1925		BALTIMORE, MD.		JAMES H. HARRIS		BALTIMORE HOSPITAL		MARY J. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF ASSISTANT		SIGNATURE OF ATTENDING		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		BALTIMORE HOSPITAL		MARY J. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

00000

CERTIFICATE OF DEATH

1920



NAME (Printed)
RESIDENCE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
SEX
AGE
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR

210-22-100
NAME (Printed)
RESIDENCE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
SEX
AGE
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF REGISTRAR



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7606 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07627

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>DAVIDSONVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Otto</u> Middle <u>H.</u> Last <u>ROSSBACK</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-5-1895</u>
9. AGE (If years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAW MILL OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WISCONSIN</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD ROSSBACK</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>MRS OLIVE ROSSBACK</u>		Address <u># 7</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO <u>434.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> (c) <u>Interval between onset and death</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. W. H. H. H.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. [Signature]</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 12 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7653

CERTIFICATE OF DEATH

Reg. Dist. No. 07628

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 32 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 902 Crain Highway NW				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Glen Burnie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 902 Crain Highway NW				d. STREET ADDRESS 1902 Crain Hghy. NW			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mamie Middle Augusta Last Ruby				4. DATE OF DEATH Month July Day 7 Year 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 3, 1894	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.		IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore County	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Theodore Metzke				14. MOTHER'S MAIDEN NAME Pauline Dalhke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mr. William W. Ruby, same as 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease DUE TO (c) Hypertensive Heart Disease INTERVAL BETWEEN ONSET AND DEATH 2-3 y.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m. Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7.5. 19 60 , to 7.7.60. 19 60 , that I last saw the deceased alive on 7.5. 19 60 , and that death occurred at 10.00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3 Crain Highway Glen Burnie, Md. DATE SIGNED ACTUAL SIGNATURE Andrew K. Szabo M.D. PHYSICIAN'S NAME (Type) Andrew K. Szabo, M.D. 3 Crain Highway SE, Glen Burnie							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/60		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE JUL 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8
7654
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07629

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) <u>Adolph</u> First <u>Schmidt</u> Middle <u>Schmidt</u> Last				4. DATE OF DEATH <u>7/16/60</u> Month <u>7</u> Day <u>16</u> Year <u>60</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18-1884</u>	
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bigges & Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. I. F.</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>215-07-4155</u>				17. INFORMANT <u>Augusta Schmidt</u> Address <u>1445 Andre ST.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO <u>Chronic Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Cardiovascular. Renal Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralytic Residual</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Baltimore</u> (County) <u>MD</u> (State) <u>MD</u>				21. I certify that (I) (this hospital) attended the deceased from <u>7/3/60</u> to <u>7/16/60</u> , that (I) (we) last saw the deceased alive on <u>7/13/60</u> , and that death occurred at <u>7:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Lipsky</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/16/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKY</u>				22d. ADDRESS <u>ODEONTOR M D</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-19-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		23d. LOCATION (City, town, or county) <u>Anne Arundel, Md.</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L Stevens</u> ADDRESS <u>1501 E. Fort Ave</u>				25a. REC'D BY REGISTRAR <u>Walter L. Hume</u>		25b. REGISTRAR'S SIGNATURE <u>Walter L. Hume</u>	
DATE <u>JUL 18 '60</u>							

10550

UNITED STATES OF AMERICA

1854

(M)

(1)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7655

CERTIFICATE OF DEATH

07630
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 1 - Box 254 B - Hunter's Harbor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>SCOTT</u> Last <u>SCOTT</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 Sept. 1911</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Murphy's 5-1st St.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harry Curray</u>				14. MOTHER'S MAIDEN NAME <u>Bertha (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>22-61-3345</u>		INFORMANT <u>Mr. Wm. G. Scott, Jr.</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>757.1</u> DUE TO <u>Polycystic kidneys, bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Congenita</u> <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>60</u> , to <u>July</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>60</u> , and that death occurred at <u>3 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis I. Codd</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Severna Park, Maryland</u> <u>7-13-60</u>			
PHYSICIAN'S NAME (Type) <u>Francis I. Codd</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12th July 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. V. Singleton</u>				ADDRESS <u>Glen Burnie Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Jul 18 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>			

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1963

DATE

TIME

PLACE

CAUSE

SIGNATURE

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Age: [illegible]

4. Date of birth: [illegible]

5. Place of birth: [illegible]

6. Date of death: [illegible]

7. Time of death: [illegible]

8. Place of death: [illegible]

9. Cause of death: [illegible]

10. Manner of death: [illegible]

11. Signature of physician: [illegible]

12. Signature of medical examiner: [illegible]

13. Signature of coroner: [illegible]

14. Signature of registrar: [illegible]

15. Signature of [illegible]: [illegible]

16. Signature of [illegible]: [illegible]

17. Signature of [illegible]: [illegible]

18. Signature of [illegible]: [illegible]

19. Signature of [illegible]: [illegible]

20. Signature of [illegible]: [illegible]

21. Signature of [illegible]: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. **02631**

1. PLACE OF DEATH a. COUNTY MILLERSVILLE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY A. ALCO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Ann's Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen First Selts Middle Box 7 Last		4. DATE OF DEATH 7/1/1960 Month 7 Day 1 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 6-1889
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse (Ret.)		9b. KIND OF BUSINESS OR INDUSTRY Self Employed	
10a. BIRTHPLACE (State or foreign country) Pa.		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. FATHER'S NAME George W. Stevenson		12. MOTHER'S MAIDEN NAME Annie Birch	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		14. SOCIAL SECURITY NO. UNKNOWN	
15. INFORMANT Helen Sterritt-Samuels Address #2			
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Disease DUE TO with decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Generalized Edema DUE TO Chronic Rheumatic Arthritis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour 6 a. m. 30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/8/60 to 7/1/60 , that I lost the deceased alive on 6/30/60 and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Lipskey M.D.		DATE SIGNED 7/1/60	
PHYSICIAN'S NAME (Type) JOSEPH LIPSEY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/3/1960	22c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery	22d. LOCATION (City, town, or county) (State) Chowsville Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert P. Wane ADDRESS St. Ann's Home		24a. REC'D BY REGISTRAR JUL 5 60 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Means

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]	
SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]	
DATE OF BIRTH [Faint text, possibly "10/15/1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]	
SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF REGISTRAR [Faint signature]	
DATE [Faint text, possibly "10/20/1955"]	

AMERICAN BOND
 CO. IN U.S.A.
 100 N. BROAD ST.
 NEW YORK 10

40

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12
 AND IS NOT VALID FOR ANY OTHER PURPOSES.
 THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, HAS RECEIVED THIS CERTIFICATE OF DEATH.
 THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, HAS RECEIVED THIS CERTIFICATE OF DEATH.
 THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, HAS RECEIVED THIS CERTIFICATE OF DEATH.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07632

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle SIMMS Last SIMMS				4. DATE OF DEATH Month July Day 27 Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1897	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	IF UNDER 24 HRS. Months 63 Days 63 Hours 63 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Maryland - Annapolis		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Clark				14. MOTHER'S MAIDEN NAME Eliza Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 213-16-1065		17. INFORMANT Florence Benson- Severna Park P.O. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Partial obstruction to left main bronchus, Superior vena cava & esophagus DUE TO (b) Carcinoma, right lung DUE TO (c) 5 mos. CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 mo.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County) Anne Arundel		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from March 1960 , to July 27, 1960 , that (I) last saw the deceased alive on July 27, 1960 , and that death occurred at 9:45 P.M. M, from the causes and on the date stated above.							
22a. SIGNATURE R. L. Richardson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/28/60		22c. PHYSICIAN'S NAME (Type) R. L. Richardson	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 30-60		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR AUG 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8780

CERTIFICATE OF DEATH

08756

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6mo. 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1840 N. Caroline Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Eva Middle Last Smith				4. DATE OF DEATH Month 7 Day 30 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1910	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (c) -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Mental Deficiency							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/19 19 60 to 7/30 19 60 , that (I) (we) last saw the deceased alive on 7/30 19 60 , and that death occurred at 11:15 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard H. Reissmann, M. D.				22b. DATE SIGNED 8/1/60			
22c. PHYSICIAN'S NAME (Type) Hildegard H. Reissmann, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, or other disposition (Specify) Buried		23b. DATE THEREOF 8/4/60		23c. NAME OF CEMETERY OR CREMATORY Antony of Maryland		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese Jr ADDRESS 108 W. W. St				25a. REC'D BY REGISTRAR DATE 8/4/60		25b. REGISTRAR'S SIGNATURE William S. France	

08750

CERTIFICATE OF DEATH

8780



[Faint, mostly illegible text on a form, likely a death certificate. The text is mirrored and difficult to decipher.]

[Handwritten signature and date at the bottom:]
1910
[Signature]

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
7657 Items 7,8,9,11,22a,b,c.&d Film G267 7/14/60 iwK 07633											
CERTIFICATE OF DEATH											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville Md.</u>						c. LENGTH OF STAY (In 1b) <u>13 Months</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>						d. STREET ADDRESS <u>4207 Pipers Mills Rd.</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Joshua</u> First <u>SMOTHERS</u> Middle <u>SMOTHERS</u> Last						DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1960</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>N.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1894?</u> <u>Sept. 4 1889?</u>		9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Moses Smothers</u>						14. MOTHER'S MAIDEN NAME <u>Victoria Payne</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperpyrexia</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Syphilis of the Central Nervous System.</u> DUE TO (c) <u>Syphilis of the Central Nervous System.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia, Epilepsy, C.B.S. due to CNS Syphilis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at <u>5:00 AM</u> from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Robert C. Snowden</u> M.D.						ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>7/14/60</u>					
PHYSICIAN'S NAME (Type) <u>Robert C. Snowden</u> M.D.						ADDRESS <u>Crownsville, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>				22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Snowden</u> ADDRESS <u>Rockville</u>						24a. REG'D BY REGISTRAR <u>JUL 11 1960</u> DATE		24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7608

07634

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>19 Mabell Ave.</i>		d. STREET ADDRESS <i>19 Mabell Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>W.</i> Middle <i>Sorrell</i> Last		4. DATE OF DEATH Month <i>7</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-1-1883</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		9. AGE (In years lost birthday) <i>77</i> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Lewis Sorrell</i>	
14. MOTHER'S MAIDEN NAME <i>Josephine Sorrell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Marion Howard</i> Address <i>19 Mabell Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer / Stomach</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>3 mos</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-6-60</i> 19____, to <i>7-11-60</i> 19____, that (I) (we) last saw the deceased alive on <i>7-10-60</i> , and that death occurred at ____ M, from the causes and on the date stated above.			
22a. SIGNATURE <i>A. T. Allen</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>		22d. ADDRESS <i>62 Cochran St</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-14-1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Sanford</i>		23d. LOCATION (City, town, or county) (State) <i>Churchton Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		25a. REC'D BY REGISTRAR <i>Anna</i> DATE <i>JUL 14 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

DIFFICULTY OF DEATH

• • •

CERTIFICATE OF DEATH

Reg. Dist. No.

07635

7609

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>22 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. Hospital</u>				e. STREET ADDRESS <u>302 7th AV. NIE.</u>			
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>H. SOUTAR</u> Last <u>(SOUTAR)</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/31/99</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u> ✓							
13. FATHER'S NAME <u>James A. Watson</u>				14. MOTHER'S MAIDEN NAME <u>Helen Cunningham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uraemia</u> DUE TO <u>Ac. + Chr. Pyelo Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ac. myocardial infarction, severe stenosis of coronary arteries</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>7/2/60</u> to <u>7/24/60</u> that I last saw the deceased alive on <u>7/24</u> , 19 <u>60</u> , and that death occurred at <u>2:53 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Maurice Klawans</u> M.D.				DATE SIGNED <u>7/24/60</u>			
PHYSICIAN'S NAME (Type) <u>MAURICE T. KLAWANS, Annapolis, Md.</u>							
22a. BURIAL, CREMATION, R. (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7658

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07636

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 W. First Ave. c. LENGTH OF STAY IN 1b 33yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooklyn Park		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 rural - Baltimore d. STREET ADDRESS 17 W. First Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amelia Margaret Spiegel		4. DATE OF DEATH Month July Day 14 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Germany
13. FATHER'S NAME August Tribull		14. MOTHER'S MAIDEN NAME Anna Dam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. August Spiegel, 206 Phelps Ave. Maryland		Address Glen Burnie, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Pancreas DUE TO 157x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/18 19 58 to 7/14 19 60 , that (I) (we) lost the deceased alive on 7-14 19 60 , and that death occurred at 5:10 AM, from the causes and on the date stated above.			
22a. SIGNATURE Morton M. Krieger		22b. DATE SIGNED 7/14/60	
22c. PHYSICIAN'S NAME (Type) Morton M. Krieger		22d. ADDRESS 5010 A Ritchie Highway	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-16-1960	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce - 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR JUL 18 60	
25b. REGISTRAR'S SIGNATURE Edward S. Jones		25c. DATE JUL 18 60	

04030

CERTIFICATE OF DEATH

1898

1898

1

1898

1898

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HIGHVIEW-ON-THE-BAY, TRACY'S LANDING,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL HOSPITAL		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Harry ELLSWORTH Stine, SR.		4. DATE OF DEATH Month Day Year July 9 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1900
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Money Orders		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.-P.O. Dept.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Stine		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Harry E. Stine, Jr., 10,217 Ridgemoor Dr., S.S. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 710.0 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Scleroderma DUE TO (c) at least 18 months		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1960 , to July 9, 1960 , that I last saw the deceased alive on July 9, 1960 , and that death occurred at 2:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard F. Smith		DATE SIGNED 7/9/60	
PHYSICIAN'S NAME (Type) WILLARD F. SMITH, MD		ADDRESS (Street, city or town, state) Shady Side, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF July 13, 1960	22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC., Raymond A. Jiska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR JUL 14 60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

7659

7638

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> COUNTY <i>A. A.</i>	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>		c. LENGTH OF STAY IN 1b <i>Mayo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Emma</i> First <i>Saylor</i> Middle <i>Saylor</i> Last		4. DATE OF DEATH Month <i>7</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-12-1894</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Butler</i>		14. MOTHER'S MAIDEN NAME <i>Gubenia Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Olda Thomas Mayo Md</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Disease - uremia</i> 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Congestive Failure</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>HL-60</i> 19 <i>60</i> to <i>7-13-60</i> , that (I) (we) lost saw the deceased alive on <i>7-12-60</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>A. T. Allen</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>		22d. ADDRESS <i>64 Cathedral St</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-17-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Hope Chapel</i>		23d. LOCATION (City, town, or county) (State) <i>Edgewater Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Keeseff</i>		25. REGISTRAR'S SIGNATURE <i>Christina S. Thomas</i>	
25a. REC'D BY REGISTRAR <i>Anna M. S.</i>		25b. REGISTRAR'S SIGNATURE	
DATE <i>JUL 22 '60</i>			

0788

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

CERTIFICATE OF DESIGN

1961

DATE

(1)



(1)

(1)



1
FOR STATE
HEALTH DEPT.

TO DELIVER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7611
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07639

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 113 Melbourne Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LESLIE		First M. Middle THOMPSON Last		4. DATE OF DEATH July 27 1960		Month July Day 27 Year 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-25-99	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William M. Thompson				14. MOTHER'S MAIDEN NAME Nannie Downs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 578-07-2705			
17. INFORMANT Dorothy B. Thompson				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemopericardium with cardiac tamponade DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Rupture of dissecting aneurysm of ascending aorta DUE TO (c) Partial						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		M.D. W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/27/60		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR F. J. Collins				24a. REC'D BY REGISTRAR 3821-14-7445-D.C.			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				DATE AUG 2 '60			

STATE
DEPT
(M)

Handwritten signature

(1)

William W. Thompson

Female Town

7-27-80

Thompson, William W.

Register of the Secretary of the State

Handwritten signature

W. Thompson, Sec. of State

7-27-80

Post Office, Thompson

1880

7-27-80

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 07640

1. PLACE OF DEATH a. COUNTY <u>A.A.C.O.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.C.O.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>	
c. LENGTH OF STAY IN 1b <u>1</u>		d. STREET ADDRESS <u>1 DILL RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. ANNE ARUNDEL GEN.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS H. TODD</u>	4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-43</u>
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u>16</u> Min. <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>THOMAS H. TODD, SR.</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SHERIDAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>914.9</u> DUE TO (a) stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Standing in water using electric drill</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7-16</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AA</u>		20f. City or town (County) (State) <u>AA</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. H. H. H.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. H. H. H.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7-16-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Severna Park</u>	22d. LOCATION (City, town, or county) (State) <u>Parkville MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barancko</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 25 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7613

CERTIFICATE OF DEATH

Reg. Dist. No.

07641

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>38 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, Annapolis, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> <u>10</u>	
		d. STREET ADDRESS <u>9 German Street</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emanuel</u> Middle <u>Joseph</u> Last <u>TOPLE</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u>		10b. KIND OF BUSINESS OR INDUSTRY -- -- -- -- --	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank TOPLE</u>		14. MOTHER'S MAIDEN NAME <u>Katherine SMERCINA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>1900-1922</u> <u>None</u>	
17. INFORMANT <u>Wife-Faith C. TOPLE, 9 German Street, Annapolis</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Prostate with Metastases</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 25th</u> , <u>1960</u> , to <u>July 15th</u> , <u>1960</u> , that I last saw the deceased alive on <u>July 15th</u> , <u>1960</u> , and that death occurred at <u>7:50A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. C. Laning</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7-15-60</u>	
PHYSICIAN'S NAME (Type) <u>R. C. LANING</u>		M.D. <u>USNH, Annapolis, Maryland</u> <u>7-15-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 19-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Laylor</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

1911

I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other competent authority.		I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other competent authority.	
Signature of Registrar		Signature of Physician	
Date		Date	
Place		Place	
Name of Deceased		Name of Deceased	
Sex		Sex	
Age		Age	
Race		Race	
Occupation		Occupation	
Cause of Death		Cause of Death	
Date of Death		Date of Death	
Place of Death		Place of Death	
Name of Physician		Name of Physician	
Signature of Physician		Signature of Physician	
Date		Date	
Place		Place	
Name of Deceased		Name of Deceased	
Sex		Sex	
Age		Age	
Race		Race	
Occupation		Occupation	
Cause of Death		Cause of Death	
Date of Death		Date of Death	
Place of Death		Place of Death	
Name of Physician		Name of Physician	
Signature of Physician		Signature of Physician	
Date		Date	
Place		Place	
Name of Deceased		Name of Deceased	
Sex		Sex	
Age		Age	
Race		Race	
Occupation		Occupation	
Cause of Death		Cause of Death	
Date of Death		Date of Death	
Place of Death		Place of Death	
Name of Physician		Name of Physician	
Signature of Physician		Signature of Physician	
Date		Date	
Place		Place	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

7660

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Central Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST DERUNDEL TUCKER</u>		4. DATE OF DEATH Month Day Year <u>July 11 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Road Maintance</u>	
11. BIRTHPLACE (State or foreign country) <u>Davidsonville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Alice Ridgeway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Miss Beatrice E. Tucker- Daughter- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Asystemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>1 yr.</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1960</u> , to <u>July 11, 1960</u> , that I last saw the deceased alive on <u>7-11-1960</u> , and that death occurred at <u>11 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5 Shaw Street Annapolis, Md.</u> DATE SIGNED <u>7/12/60</u>			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		PHYSICIAN'S NAME (Type) <u>James R. Martin MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 14, 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>All Hallows Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Birdsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Head</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, retain, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. BIRTH DATE		8. BIRTH PLACE		9. BIRTH DATE		10. BIRTH PLACE	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF DECEASED		19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED		25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED		37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED		43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED		49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED		55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED		67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED		73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED		76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED		79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED		85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED		97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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N
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07643

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosalie PORTER VAN NESS		4. DATE OF DEATH Month Day Year July 16 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12 th 1881
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Theodorice Porter		14. MOTHER'S MAIDEN NAME Bettie Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Carroll Van Ness Owings Mills Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) Chronic suppurative		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 7-16-1960, that (I) (we) last saw the deceased alive on 7-16-1960 and that death occurred at 7 P.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature] M.D.		22b. DATE SIGNED 7/18/60	
22c. PHYSICIAN'S NAME (Type) Elmer G. Linhardt		22d. ADDRESS 3 Chesapeake Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 19-1960	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemt.		23d. LOCATION (City, town, or county) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		25a. REC'D BY REGISTRAR ADDRESS Annapolis Md	
25b. REGISTRAR'S SIGNATURE		25c. DATE JUL 21 1960	

(M)

1914

CERTIFICATE OF DEATH

1914

(M)

County of ... State of ...

...

...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the above is necessary, please enclose a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Howard ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade				c. LENGTH OF STAY IN lb Few seconds			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle - Last VITALI				4. DATE OF DEATH Month July Day 1 Year 19 60			
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/21/26	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 33 Days 33		IF UNDER 24 HRS. Hours 33 Min. 33			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Salzburg, Austria	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - No				16. SOCIAL SECURITY NO. 118-28-9609		17. INFORMANT (Husband) SP5 Richard J Vitali	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgin's disease DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-6-60		22c. NAME OF CEMETERY OR CREMATORY National	
22d. LOCATION (City, town, or county) Arlington, Va.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F.C.Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR JUL 6 '60		24b. REGISTRAR'S SIGNATURE Arthur B. Thomas	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7662

CERTIFICATE OF DEATH

Reg. Dist. **07645**

1. PLACE OF DEATH a. COUNTY AA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towell c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towell d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Wallace Last Wallace		4. DATE OF DEATH Month 7 Day 12 Year 1960			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4,	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR: Months 8 Days 9 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry C. Wallace		14. MOTHER'S MAIDEN NAME Hydia Pratt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-30389		17. INFORMANT John Wallace, Dunbar, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atheriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from May 1960 to July 12, 1960 , that I last saw the deceased alive on June 1, 1960 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7-14-60 DATE SIGNED 7-14-60					
ACTUAL SIGNATURE Emily H. Nelson		M.D. Lottman, Md.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-16-60		22c. NAME OF CEMETERY OR CREMATORY Moses	
22d. LOCATION (City, town, or county) Bristol A.A. Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell, Prince Frederick		ADDRESS		24a. REC'D BY REGISTRAR JUL 19 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kirsch					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM WATKINS JR.</u>		4. DATE OF DEATH Month Day Year <u>7 3 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-1901</u>
9. AGE (In years last birthday) yrs. <u>58</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker-Supply-U.S.N. Acad.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ANNAPOLIS, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WATKINS Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Sophie HARRIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Elizabeth-Watkins</u>		Address <u>ANNA, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO (b) <u>Myocardial Damage</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>6 am</u> <u>6 am</u> <u>15:40</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/2</u> , 19 <u>60</u> , to <u>7/3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/3</u> , 19 <u>60</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson, Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>37 Calvert St., Annapolis, Md.</u> <u>7/5/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-6-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CARVER MEMORIAL</u>	22d. LOCATION (City, town, or county) (State) <u>LAUREL - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 12 '60</u>	
ADDRESS <u>ANNAPOLIS-MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

A.A.

M.D.

1911

11

An individual

Available

for this purpose

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7616

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS Rt-2, Box-213C.			
3. NAME OF DECEASED (Type or print) First Middle Last Leonard E. WEAVER				4. DATE OF DEATH Month Day Year July 22 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1903	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Naval architect				10b. KIND OF BUSINESS OR INDUSTRY Architect		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William E. Weaver				14. MOTHER'S MAIDEN NAME Minnie Jacobs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Elma R. Weaver (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 561.4 Septicemia DUE TO (b) Post operative wound infection & empyema 6 da DUE TO (c) Hiatal hernia repair and esophageal exploration 10 da PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 7, 1960, to July 21, 1960, that (I) (we) last saw the deceased alive on July 21, 1960, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE Barber C. Palmer, Jr.				22b. ADDRESS 77 Franklin St., Annapolis, Md.		22c. PHYSICIAN'S NAME (Type) Barber C. Palmer	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 7-25-60				23b. DATE THEREOF 7-25-60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
23d. LOCATION (City, town, or county) Prince George's Co. Md.				23e. REGISTRAR'S SIGNATURE Arthur L. Kraus		23f. REGISTRAR'S SIGNATURE	

010-2

1018

10

1

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one certificate is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

7663

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07648

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 3558 West Shote Rd. Green Haven</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Henry Weidenhoft</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5th.</u> Year <u>19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/13/86</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired conductor of The P.R.R.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany, Europe.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Weidenhoft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>717-07-8386</u>		17. INFORMANT Address <u>Mrs. Edna Weidenhoft (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/5/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-8-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clady - 130 E. Towson Ave.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUL 8 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07649

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.CO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.M. ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>Severn Hqts.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Wheatly</u> Last <u>Wheatly</u>				4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-21-35</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u>24</u> Min. <u>24</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Academy-Annapolis</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. City - Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Kayhn Shinaberry</u>				14. MOTHER'S MAIDEN NAME <u>Helen V. Ryder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Bertha Bocock - Marley Park -</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>825 X</u> DUE TO (c) <u>Sudden</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - Reliance Square Cypress Creek Road</u>			
20c. TIME OF INJURY Month, Day, Year <u>Hour 11:35 p.m. 7-16 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>A.A.CO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>7.16.60.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>20 July 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Severna Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. S. Singleton</u>				24a. REC'D BY REGISTRAR <u>Jul 21 '60</u>			
ADDRESS <u>Severna Park, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Charles S. Hearn</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH CERTIFICATE (To be filled out by the Medical Examiner)		DEATH CERTIFICATE (To be filled out by the Medical Examiner)	
NAME OF DECEASED _____		NAME OF DECEASED _____	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		AGE _____	
DATE OF DEATH _____		DATE OF DEATH _____	
TIME OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		PLACE OF DEATH _____	
OCCASION OF DEATH _____		OCCASION OF DEATH _____	
CAUSE OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF MEDICAL EXAMINER _____	
TITLE OF MEDICAL EXAMINER _____		TITLE OF MEDICAL EXAMINER _____	
ADDRESS OF MEDICAL EXAMINER _____		ADDRESS OF MEDICAL EXAMINER _____	
CITY OF MEDICAL EXAMINER _____		CITY OF MEDICAL EXAMINER _____	
STATE OF MEDICAL EXAMINER _____		STATE OF MEDICAL EXAMINER _____	
COUNTY OF MEDICAL EXAMINER _____		COUNTY OF MEDICAL EXAMINER _____	
ZIP CODE OF MEDICAL EXAMINER _____		ZIP CODE OF MEDICAL EXAMINER _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF DECEASED _____	
TITLE OF DECEASED _____		TITLE OF DECEASED _____	
ADDRESS OF DECEASED _____		ADDRESS OF DECEASED _____	
CITY OF DECEASED _____		CITY OF DECEASED _____	
STATE OF DECEASED _____		STATE OF DECEASED _____	
COUNTY OF DECEASED _____		COUNTY OF DECEASED _____	
ZIP CODE OF DECEASED _____		ZIP CODE OF DECEASED _____	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

7664
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07650

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 14 th. Ave.		d. STREET ADDRESS 101 14th Ave.	
3. NAME OF DECEASED (Type or print) First VIOLA Middle WILLIAM Last		4. DATE OF DEATH Month July Day 19 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George T. Stinchcomb		14. MOTHER'S MAIDEN NAME Ida M. Parrish	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-6091	
17. INFORMANT Mr. Lee G. Williar		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 41XX DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/13 19 60 to 7/19 19 60 that (I) (we) last saw the deceased alive on 7/19 19 60 , and that death occurred at 5:16 AM from the causes and on the date stated above.			
22a. SIGNATURE Morton M. Krieger		22b. DATE SIGNED July 20, 1960	
22c. PHYSICIAN'S NAME (Type) Morton M. Krieger		22d. ADDRESS 5010 A Gov. Ritchie Hwy. Balt & Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 21, 1960	
23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ray J. Jones		25a. REC'D BY REGISTRAR DATE JUL 25 '60	
ADDRESS 4001 Ritchie Hwy. Balto 25		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

UNITED STATES OF AMERICA

1965

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James A. ...

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

7665

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07651

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>101 Greeway Rd. Ma/rley Park</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Terry Lee Windeshein</u>				4. DATE OF DEATH Month Day Year <u>July 9th 1960 19</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/18/58</u>		9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Windeshein</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Lilley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr and Mrs. J. Windeshein (parents.)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <u>527.2</u> IMMEDIATE CAUSE (a) <u>Acute pulmonary infection</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/9/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12th July 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. P. Sings</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 13 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

7666

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. H.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>STENBOURNE</i>		c. LENGTH OF STAY IN 1b <i>10</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Staten</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>211 Hollywood Rd.</i>				d. STREET ADDRESS <i>211 Holly wood Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Charlotte</i> Middle <i>Leah</i> Last <i>Hall</i>				4. DATE OF DEATH Month <i>7</i> Day <i>31</i> Year <i>1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-26-87</i>		9. AGE (In years last birthday) <i>73</i> yrs.	IF UNDER 1 YEAR Months <i>12</i> Days <i>12</i> Hours <i>12</i> Min.	IF UNDER 24 HRS. Hours <i>12</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ind.</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Gabriel Solomon</i>				14. MOTHER'S MAIDEN NAME <i>Mary E. Solomon</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>[blank]</i>		INFORMANT <i>Family - Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arterio-sclerotic heart disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>						INTERVAL BETWEEN ONSET AND DEATH <i>many years</i>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>5</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>Febr. 4, 1958</i> to <i>July 20, 1960</i> , that I last saw the deceased alive on <i>July 21, 1960</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Florian P. Nadolski</i>		ADDRESS (Street, city or town, state) <i>2703 Hammond Perry Rd Baltimore 27, Md</i>		DATE SIGNED <i>7-22-60</i>			
PHYSICIAN'S NAME (Type) <i>Florian P. Nadolski, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>7-23-60</i>		22b. DATE THEREOF <i>7-23-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McClary - 130 E Fort Ave.</i>				ADDRESS <i>[blank]</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 27 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7667

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07653

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ernest Middle Young Last Young				4. DATE OF DEATH Month July Day 30 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1901	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.		IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - COOK				10b. KIND OF BUSINESS OR INDUSTRY Unknown			
11. BIRTHPLACE (State or foreign country) Unknown Annapolis, Md.				12. CITIZEN OF WHAT COUNTRY? Unknown U.S.A.			
13. FATHER'S NAME William Parker				14. MOTHER'S MAIDEN NAME Ella Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown NO				16. SOCIAL SECURITY NO. 226-18-1436			
17. INFORMANT Mrs. Alice Brown-A.A.Co. D.P.W.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardio renal vascular disease 4-4-2 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH ? yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 11, 1960 to July 30, 1960 that (I) (was) last saw the deceased alive on July 23, 1960 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE James M. Pair				22b. DATE SIGNED July 30, 1960			
22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.				22d. ADDRESS 400 N. Carrollton Ave. Balto. 23, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 2-60		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town, or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE G.E. Hick				25a. REC'D BY REGISTRAR Aug 3 '60			
ADDRESS 111 Annapolis, Maryland				25b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1911

07000



Form with multiple sections for recording death statistics, including fields for name, age, sex, race, cause of death, and date of death. The form is partially filled out with handwritten text.

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
CAUSE OF DEATH: [illegible]
DATE OF DEATH: [illegible]